

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2392

CERTIFICATE OF DEATH

02368

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY Franklin									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fayetteville											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS R.F.D. #2		e. IS RESIDENCE ON A FARM? 75 X-1		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) RAYMOND		First FRANK	Middle ANGLE	Last FRANKLIN	4. DATE OF DEATH February 19 1961	Month February	Day 19	Year 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 13, 1895		9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel Operator		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (County & State, or foreign country) Franklin County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Benjamin Franklin Angle		14. MOTHER'S MAIDEN NAME Lucy Corbett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. I		16. SOCIAL SECURITY NO. 180-26-7016		17. INFORMANT Mrs. Elva Angle		Address Fayetteville, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452 X		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Respiratory & Circulatory failure Subarachnoid hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH 1 wk.							
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO (c) Ruptured aneurysm of anterior communicating artery											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year February 19, 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chambersburg		(County) Pa.		(State) Pa.			
21. I certify that (I) (this hospital) attended the deceased from February 12, 1961 , to February 19, 1961 , that (I) (we) last saw the deceased alive on February 19, 1961 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.		22e. SIGNATURE A. F. Abdullah		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/21/1961			
22c. PHYSICIAN'S NAME (Type) A. F. Abdullah, M.D.		22d. ADDRESS 132 N. Potomac, Hagerstown, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/22/1961		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Cemetery		23d. LOCATION (City, town or county) Chambersburg		(State) Pa.							
24. FUNERAL DIRECTOR'S SIGNATURE Suter Rouzer Funeral Home		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

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Task 2: *Group nomination*

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Total 500

• *It is important to remember that the following are not the only ways to evaluate a company.*

THE BOSTONIAN SOCIETY

ANSWER

THE BOSTONIAN

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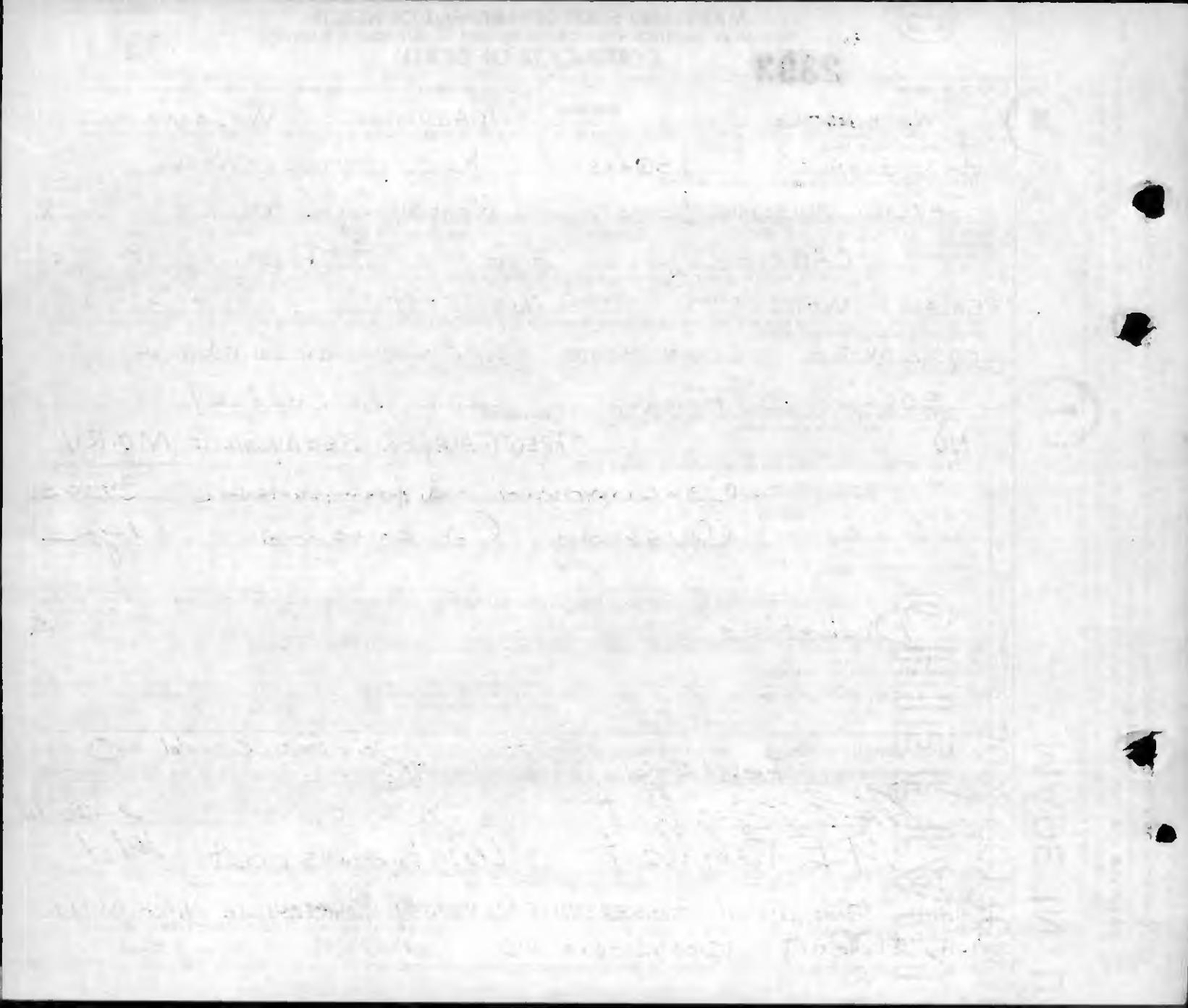
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02369

2393

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 23 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KEEDYSVILLE - RURAL					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARLOCK NURSING HOME		d. STREET ADDRESS X KEEDYSVILLE MD. R.I.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CARRIE		First M.	Middle A.	Last AVEY	4. DATE OF DEATH FEBRUARY, 18. 1961	Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MAY. 15 - 1903	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 9	Days 3	Hours Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) EDGEWOOD WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME EDGAR B. FORREST		14. MOTHER'S MAIDEN NAME ADA M. SHEPLEY		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 175-00-0000		17. INFORMANT FRED T. AVEY SR. KEEDYSVILLE MD. R.I.		INTERVAL BETWEEN ONSET AND DEATH 3 mos			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175-00-0000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Carcinoma diffuse metastatic Ovarian Carcinoma		Diabetics		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Diabetics		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Williamsport MD.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 1 1958 to Feb 18 1961 , that (I) (we) last saw the deceased alive on Feb 12 1961 , and that death occurred at 7:30 AM , from the causes and on the date stated above.		22a. SIGNATURE M. E. Bryant		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-20-61			
22c. PHYSICIAN'S NAME (Type) M. E. Bryant		22d. ADDRESS Williamsport MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF FEB 21 1961		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ROHRERSVILLE CEMETERY Boonsboro MD.		23d. LOCATION (City, town, or county) ROHRERSVILLE WASH. CO. MD.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Scott		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exhibited within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

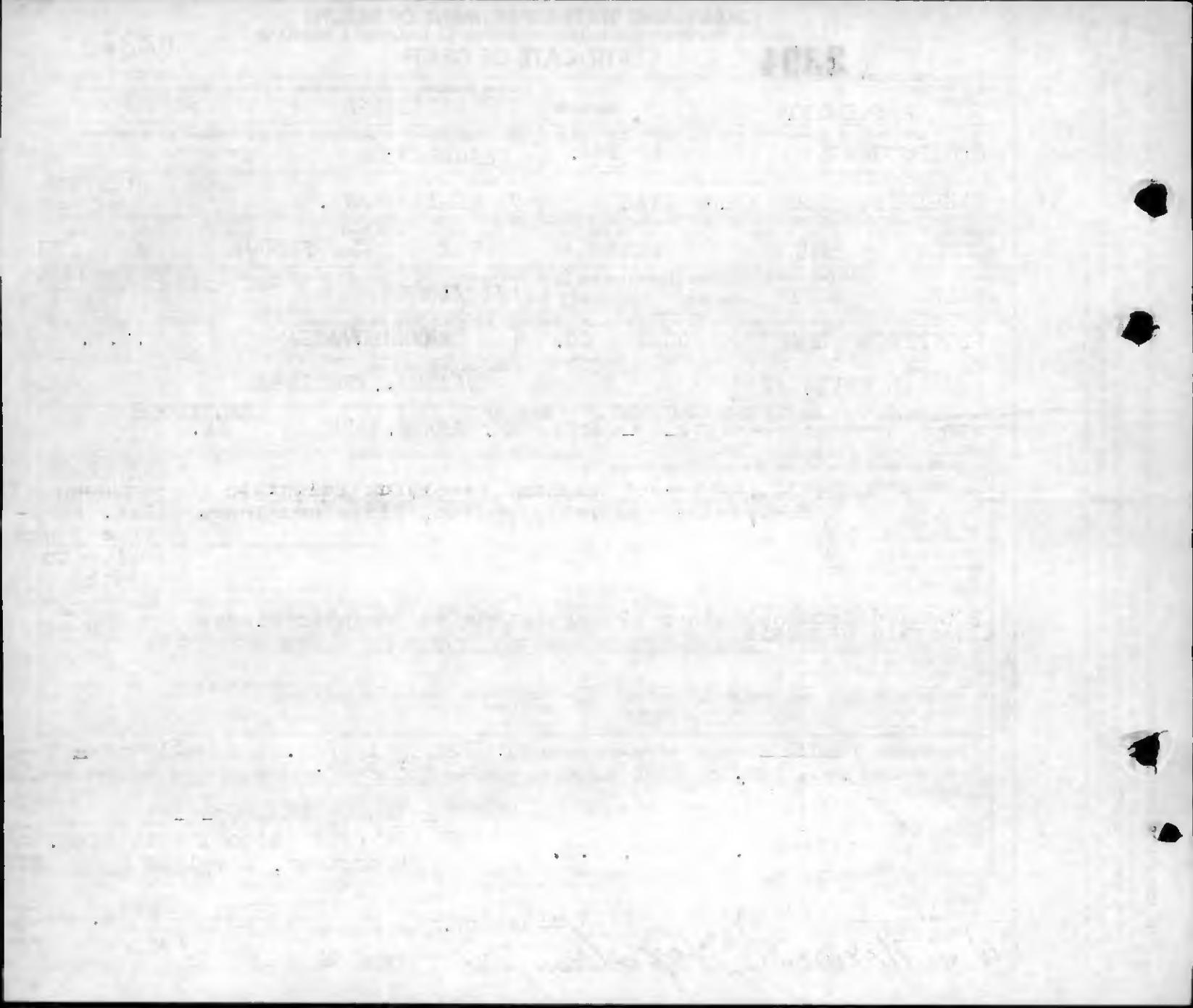
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2394

CERTIFICATE OF DEATH

02370

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. STREET ADDRESS 76 MADISON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HARRY	Middle JACOB	Last AVEY
4. DATE OF DEATH	Month FEBRUARY	Day 4	Year 19 61
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/1886
9. AGE (In years last birthday) 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) RETIRED MOLEADER	11. KIND OF BUSINESS OR INDUSTRY FOUNDRY CO.	12. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME SAMUEL ERVIN AVEY	14. MOTHER'S MAIDEN NAME NANCY J. ROBINSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no) NO	16. SOCIAL SECURITY NO. 214-09-2442A	17. INFORMANT MR. MAX S. AVEY	BALTIMORE MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Lymphoma involving lymphatic</u> 200-3 DUE TO system generally spleen, liver and lungs Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (1) Healed Duodenal ulcer (2) Hypertensive Vascular Disease (3) Aortic Stenosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Jan. Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 28 1961, to Feb. 4 1961, that (I) (we) last saw the deceased alive on Feb. 4 1961, and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE <i>W. T. Layman, M.D.</i>	22b. DATE SIGNED 2-6-61		
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.	22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/7/61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS GREEN HILL CEM.	23d. LOCATION (City, town, or county) (State) WAYNESBORO PENNA.
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norman, Hagerstown, Md.</i>	25a. REC'D BY REGISTRAR DATE FEB. 8 '61	25b. REGISTRAR'S SIGNATURE <i>Orlin S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2395

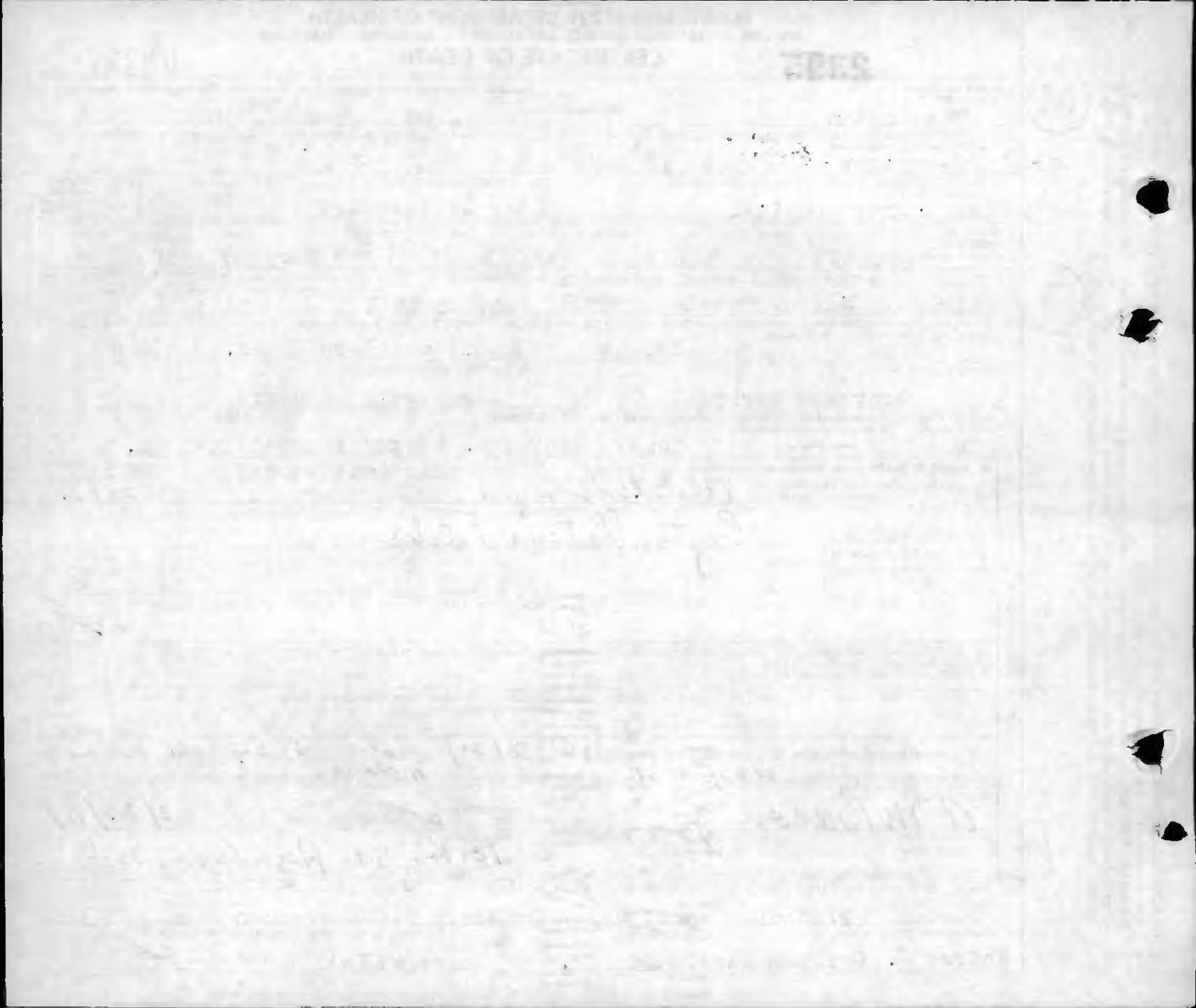
CERTIFICATE OF DEATH

303

02371

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 5		d. STREET ADDRESS near Leitersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GLENN		First	Middle	Lost	4. DATE OF DEATH Feby 22 1961	Month	Day	Year 19	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feby 21 1961	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 1	Hours 0	
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Grover C Barkdoll		14. MOTHER'S MAIDEN NAME Margarettal Lindberg							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Grover C. Barkdoll Hagerstown Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Atelectasis Severe		DUE TO 770		R # 5 near Leitersburg		INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Erythroblastosis Fetalis		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/21/1961 to 2/24/1961 , that (I) (we) last saw the deceased alive on 2/24/1961 , and that death occurred at 11:58 AM from the causes and on the date stated above.									
22a. SIGNATURE Am Bacon Jr		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/23/61					
22c. PHYSICIAN'S NAME (Type) 		22d. ADDRESS 101 King St. Hagerstown, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23/61		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md			(State)
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR FEB 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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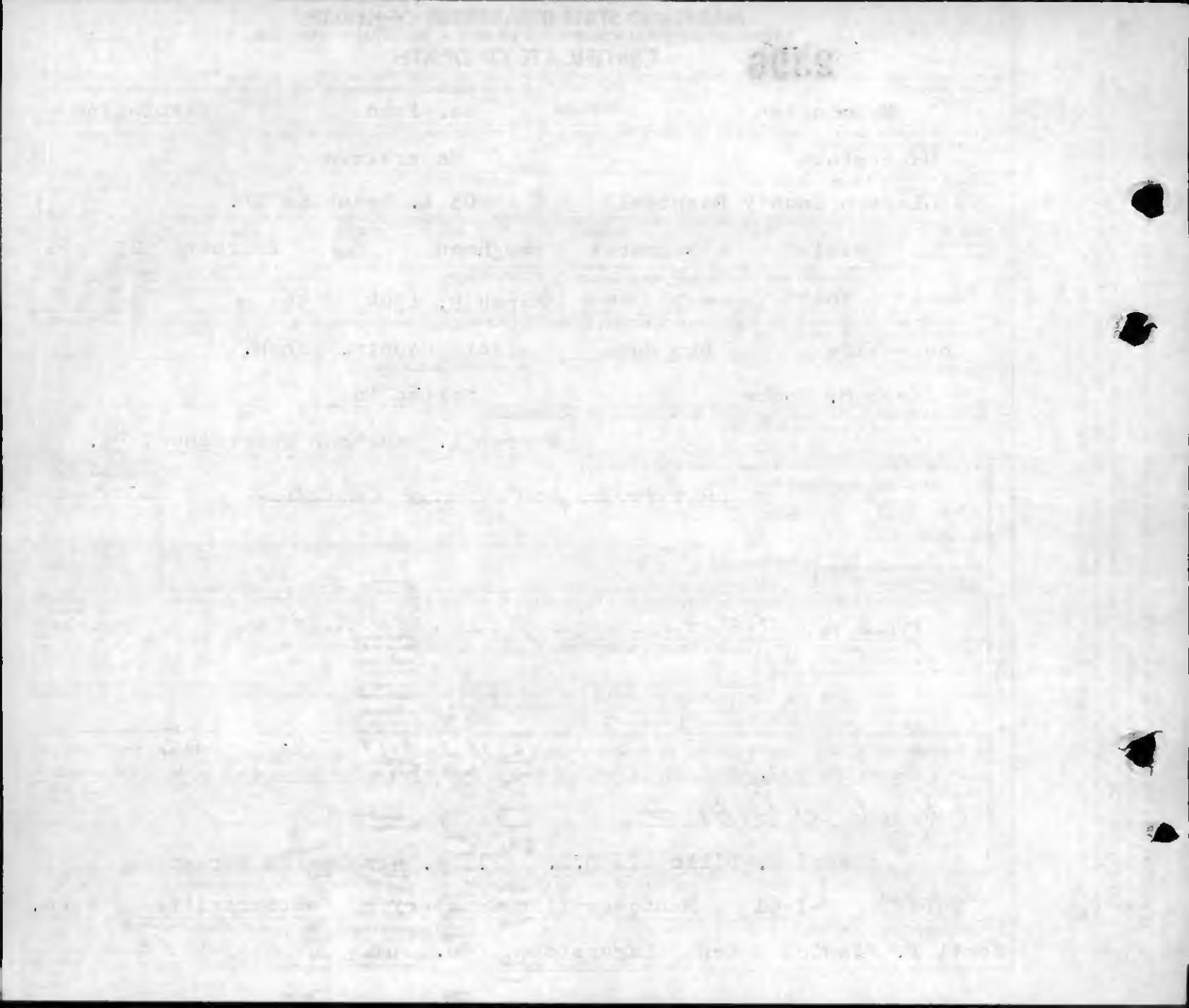
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2396

CERTIFICATE OF DEATH

02372

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Margaret	Last Baughman
4. DATE OF DEATH	Month February	Day 25	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1904
9. AGE (In years last birthday) 56	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) York County, Penn.
13. FATHER'S NAME Jacob H. Spahr	14. MOTHER'S MAIDEN NAME Martha May	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT Warren L. Baughman Hagerstown, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465 X DUE TO massive pulmonary embolism INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) 20 Mar -			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - gangrene left great toe. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/11 , 1961, to 2/25 , 1961, that (I) (we) last saw the deceased alive on 2/25 , 1961, and that death occurred at 9:20 M , from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Dill III	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward W. Dill III M.D.	22d. ADDRESS 217 W. Washington Street		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-1-61	23c. NAME OF CEMETERY OR CREMATORIUM Montoursville Cemetery	23d. LOCATION (City, town, or county) (State) Montoursville Penn.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son	ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR DATE MAR 1 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02373

230

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Hagerstown PDG		e. STREET ADDRESS Hagerstown PDG		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDITH	First VIRGINIA	Middle BESECKER	Last EDITH	4. DATE OF DEATH Feb. 28 1961	Month Feb. Day 28 Year 1961
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/5/1899	9. AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Mason-Dixon, Pa.	
13. FATHER'S NAME HARMON L. SHUCK		14. MOTHER'S MAIDEN NAME Mary Margaret Burkett		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT Edward J. Besecker Address RDG Hagerstown, md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) ANEMIA APLASTIC DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under-lying cause last. 723 (b) DUE TO (c) ARTHRITIS RHEUMATOID DUE TO (d) INTERVAL BETWEEN ONSET AND DEATH 4 mo					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) Wash. Co. (State) md.		
21. I certify that (I) (this hospital) attended the deceased from 2-16 1961 to 2-20 1961 , that (I) (we) last saw the deceased alive on 2-27 1961 , and that death occurred at M. from the causes and on the date stated above					
22a. SIGNATURE Dr. E. W. Pitt Jr. M.D.			22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dr. E. W. Pitt Jr.		
23a. BURIAL CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF 3/3/61	23c. NAME OF CEMETERY OR CREMATORIAL Beautiful View	23d. LOCATION (City, town, or County) Wash. Co. md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Mennick - Greencastle		ADDRESS	25a. REC'D BY REGISTRAR DATE MAR 6 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Haas	



MARYLAND STATE DEPARTMENT OF HEALTH

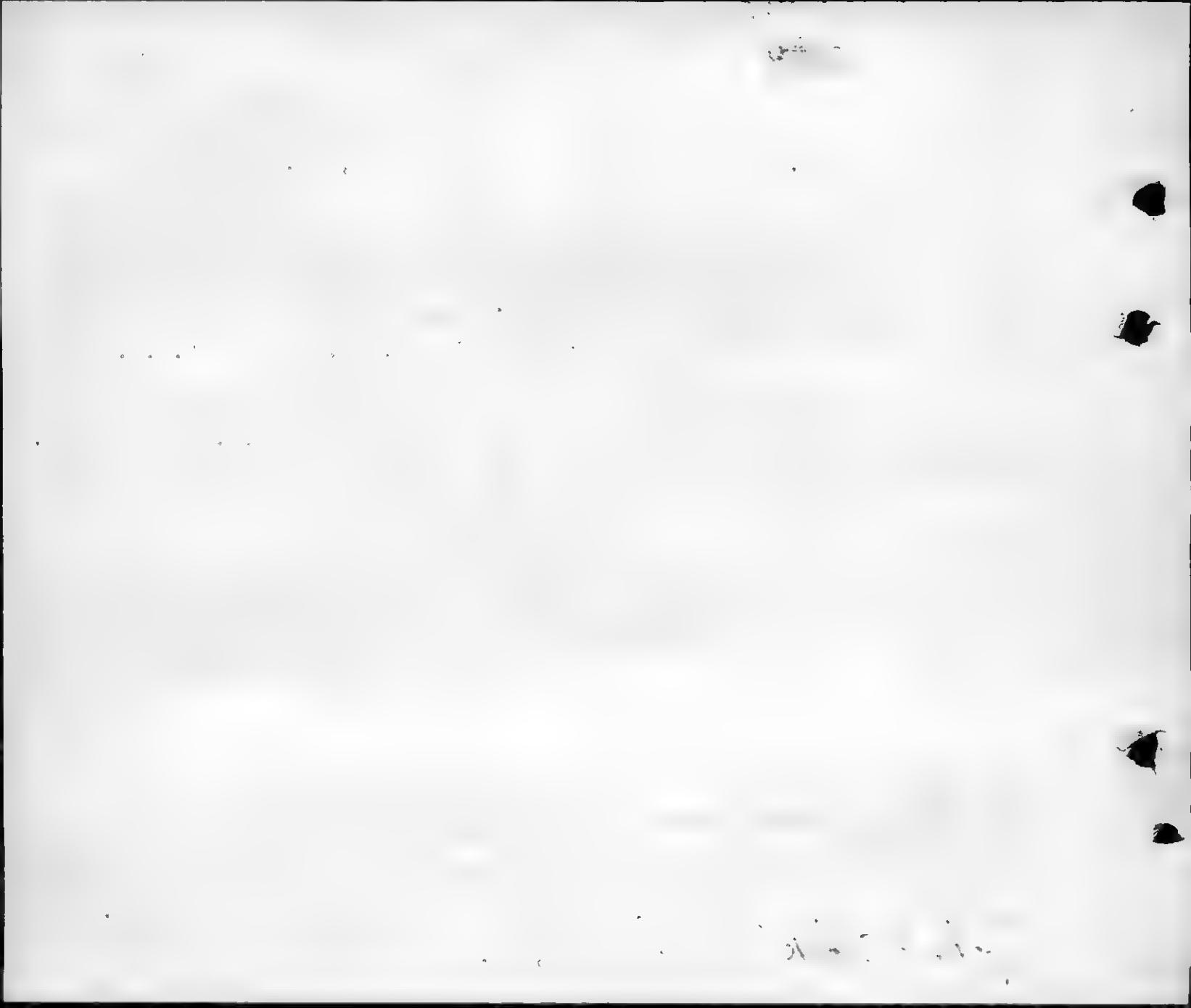
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2398

CERTIFICATE OF DEATH

12374

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHING'ON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN, MD.		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. ROUTE 1		d. STREET ADDRESS NONE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELEANOR		First	Middle	Last	4. DATE OF DEATH FEBRUARY 10 1961	Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 29, 1896	9. AGE (in years last birthday) 65 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME DUTIES		11. BIRTHPLACE (State or foreign country) WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME BERTHA SHANK					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RICHARD BLOYER		Address CLSPG. MD. ROUTE 1.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure									
DUE TO Intracerebral hemorrhage									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Severe hypertension									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Senile arthritis									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Febr 10 1961 to Febr 11 1961 , that (I) (we) last saw the deceased alive on Febr 10 1961 , and that death occurred at AM from the causes and on the date stated above									
22a. SIGNATURE John C. Stauffer		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) John C. Stauffer		22d. ADDRESS							
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 13, 1961		23c. NAME OF CEMETERY OR CREMATORIUM ST. PAULS CEMETERY		23d. LOCATION (City, town, or county) WASHINGTON CO. MD.			(State)
24. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Tamm			



TO HOSPITAL may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

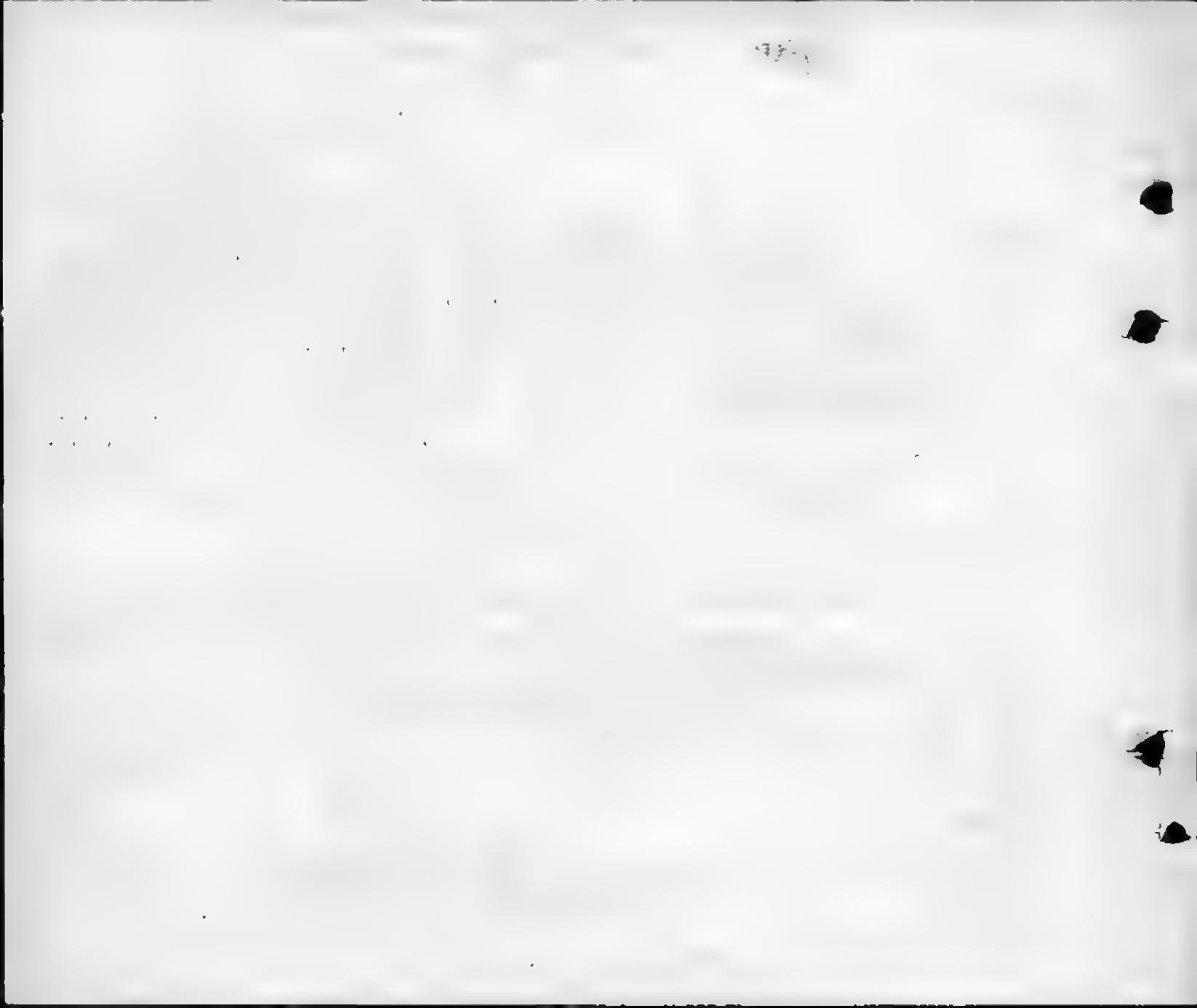
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2399

CERTIFICATE OF DEATH

Reg. Dist. No. 1237

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna.		b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro		75 X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 2 East Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle LANNING	Last BOWLEY	4. DATE OF DEATH	Month Feb.	Day 15	Year 1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 22, 1876	05	0	0	0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Piano builder		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oxford Furnace, N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Hazelett Bowlby				14. MOTHER'S MAIDEN NAME Mahala Lanning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO ----		17. INFORMANT Miss Ethel D. Stickles, 4801 Conn. Ave., N.W.		Address Wash. 8, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 4.20.1 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i> DUE TO <i>reding</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) none							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1961</u> to <u>Feb 15, 1961</u> that I last saw the deceased alive on <u>Feb 14, 1961</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>M.E. Byrkit</u> M.D. <u>28 w Potowac 2-17-61</u> PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u> <u>Williamsport Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/1961		22c. NAME OF CEMETERY OR CEMINATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Martin Roe</u>				ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR DATE FEB 20 '61	
						24b. REGISTRAR'S SIGNATURE <u>John S. Kraus</u>	



TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

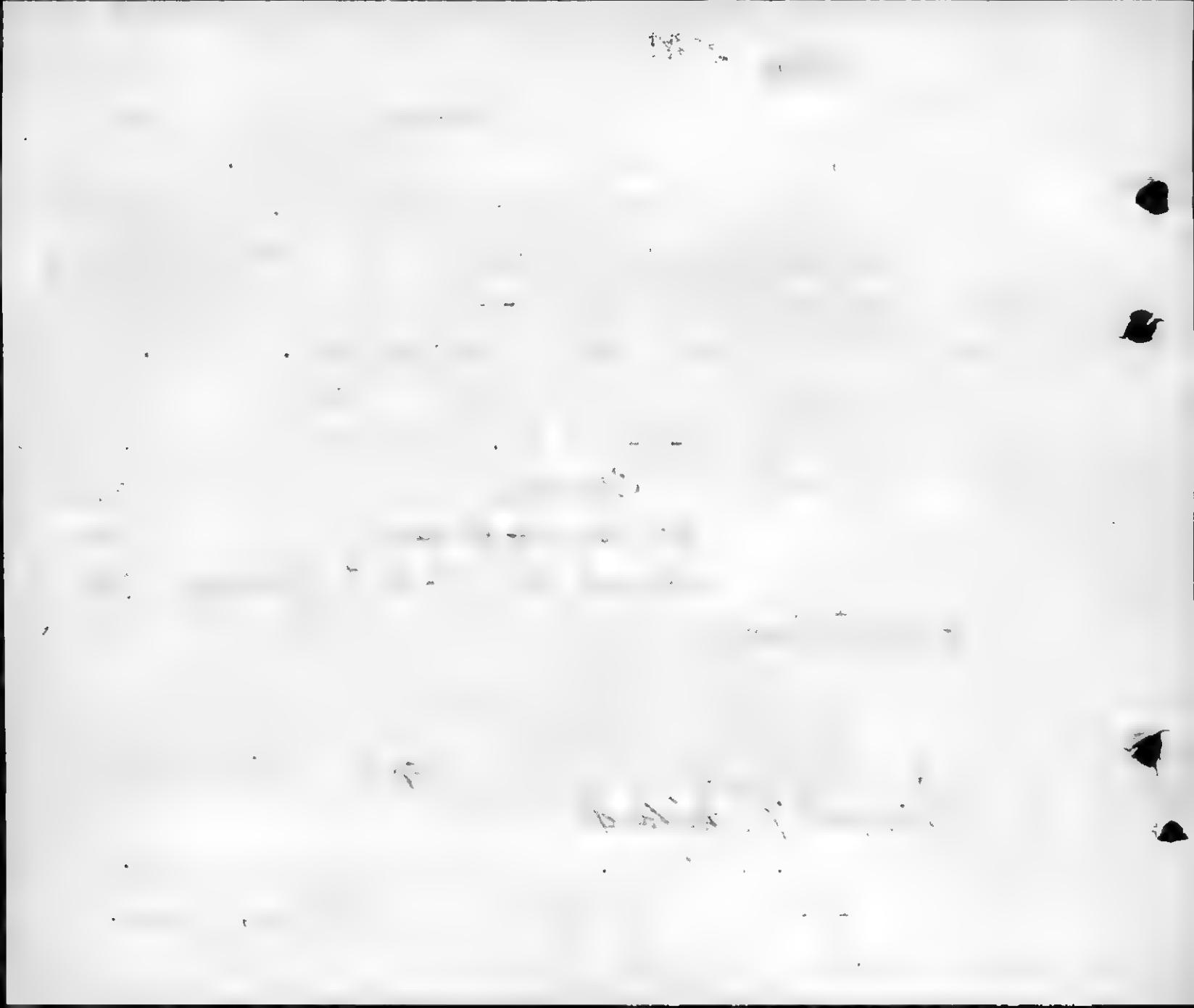
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2400 02374

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lena Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS RT #2, BOONSBORO, Mo.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lawrence	Middle William	Last Briscoe
4. DATE OF DEATH	Month Feb	Year 20	Day 19 61
S. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1893
9. AGE (in years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Jewelry store	
11. BIRTHPLACE (State or foreign country) Clear Spring Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME George Briscoe		14. MOTHER'S MAIDEN NAME Isabella Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-20-9151	
17. INFORMANT Mrs. Juanita Briscoe		Address RT #2 Boonsboro, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>12</i> Otremia INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). Nephrosclerosis 1-2 yrs.			
DUE TO Arterosclerotic heart disease years.			
DUE TO Hypertension 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 29 Dec. 1960 to 20 Feb. 1961 that (I) (we) last saw the deceased alive on 20 Feb. 1961 and that death occurred at 92M , from the causes and on the date stated above			
22a. SIGNATURE <i>Richard T. Binford</i>		22b. DATE SIGNED 2/23/61	
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		22d. ADDRESS 1135 POTOMAC AVE. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-1961	
23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Watson Jr. Hagerstown Md</i>		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>	



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2401 Item 1 Film 6202 3-2-61

1. PLACE OF DEATH
 a. COUNTY Washington MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown

c. LENGTH OF STAY IN 1b Life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home -- 913 Kenwood Drive

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
 a. STATE Maryland b. COUNTY Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown

d. STREET ADDRESS 913 Kenwood Drive

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) First Middle Last **4. DATE OF DEATH** Month Day Year
 Frederick Musey Carty February 22 19 61

5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH April 24, 1890
 Male White WIDOWED DIVORCED 9. AGE (In years lost birthday) 70 yrs.
 Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman 10b. KIND OF BUSINESS OR INDUSTRY Organ 11. BIRTHPLACE (State or foreign country) Hagerstown, md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Emery Carty 14. MOTHER'S MAIDEN NAME Alice Dayhoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO 17. INFORMANT Address
 If yes, give war or dates of service) 214-09-0401 Mrs. Icia O. Carty Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arterio sclerotic heart disease, 1 yr.
 42 0.0 DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arterio sclerosis
 (c) cerebral arterio sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day Year (County) (State)
 Hour a.m. While Nat while factory, street, office bldg., etc.) 20d. INJURY OCCURRED Month Day Year (City or town)
 p.m. at work at work

21. I certify that (I) (this hospital) attended the deceased from March 6, 1958, to Feb 22, 1961, that (I) (we) last saw the deceased alive on Feb 22, 1961, and that death occurred at 9 AM, from the causes and on the date stated above

22a. SIGNATURE Sidney Mowerskin M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED 2-22-61

22c. PHYSICIAN'S NAME (Type) Sidney Mowerskin 22d. ADDRESS Hagerstown Md.

23a. BURIAL, CREMATION OR REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town, or county) (State)
 Burial 2-25-61 Rose Hill Cemetery Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
 Scott F. Minnich & Son, Hagerstown, Md. FEB 27 61 Clinton S. Minnich

VR A15 (4)
 ISM 9/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exempted from 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2402

CERTIFICATE OF DEATH

4237

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

Hagerstown

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION [if not in hospital, give street address]

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

George

Jacob

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

April 23, 1896

10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]

Machinist

10b. KIND OF BUSINESS OR INDUSTRY

Aircraft

13. FATHER'S NAME

John. W. Cline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] [If yes give war or dates of service]

No

16. SOCIAL SECURITY NO. | 17. INFORMANT

217-10-2627 Geo. J. Cline Jr. 2207 Gay St. Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

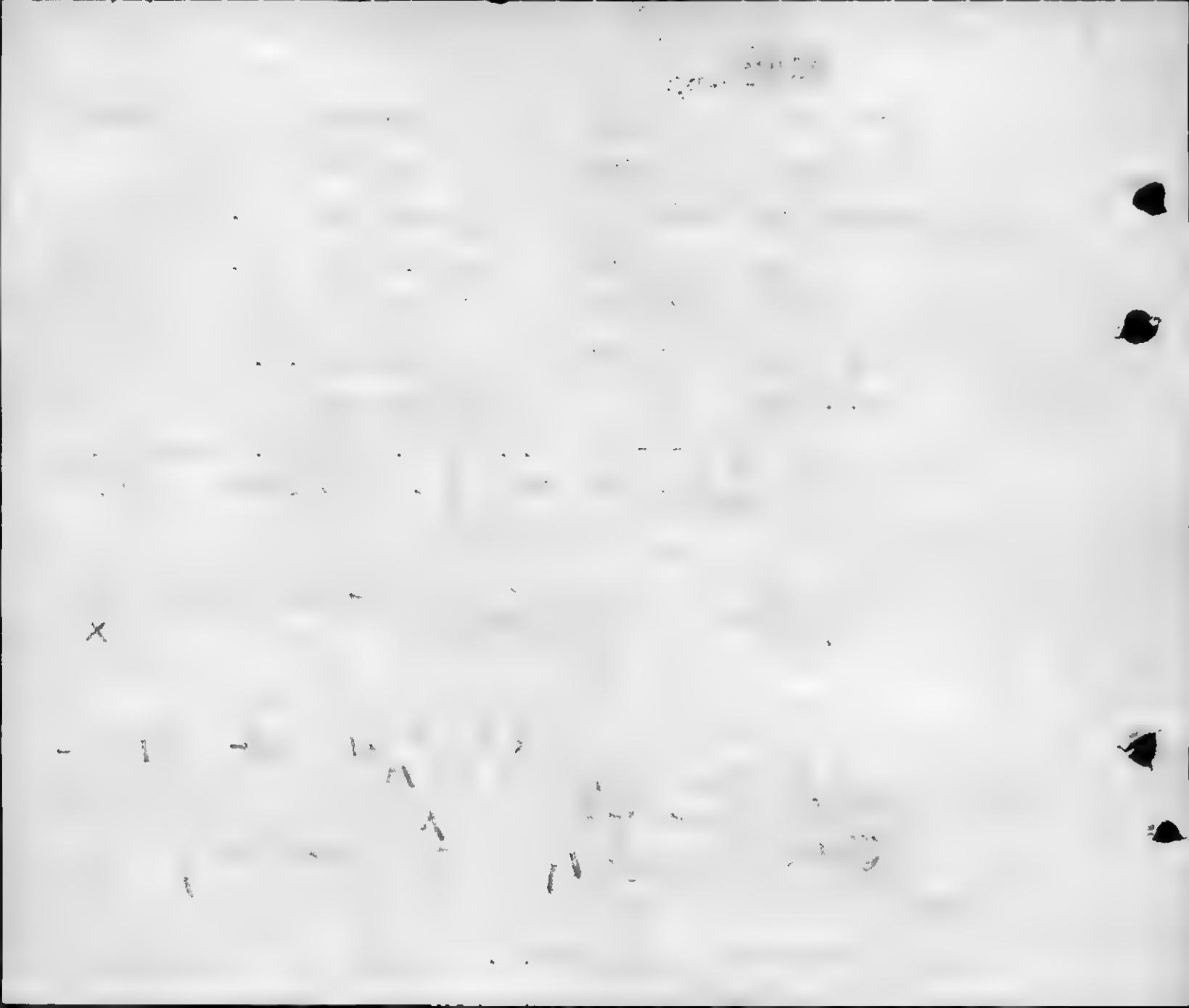
1 538 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

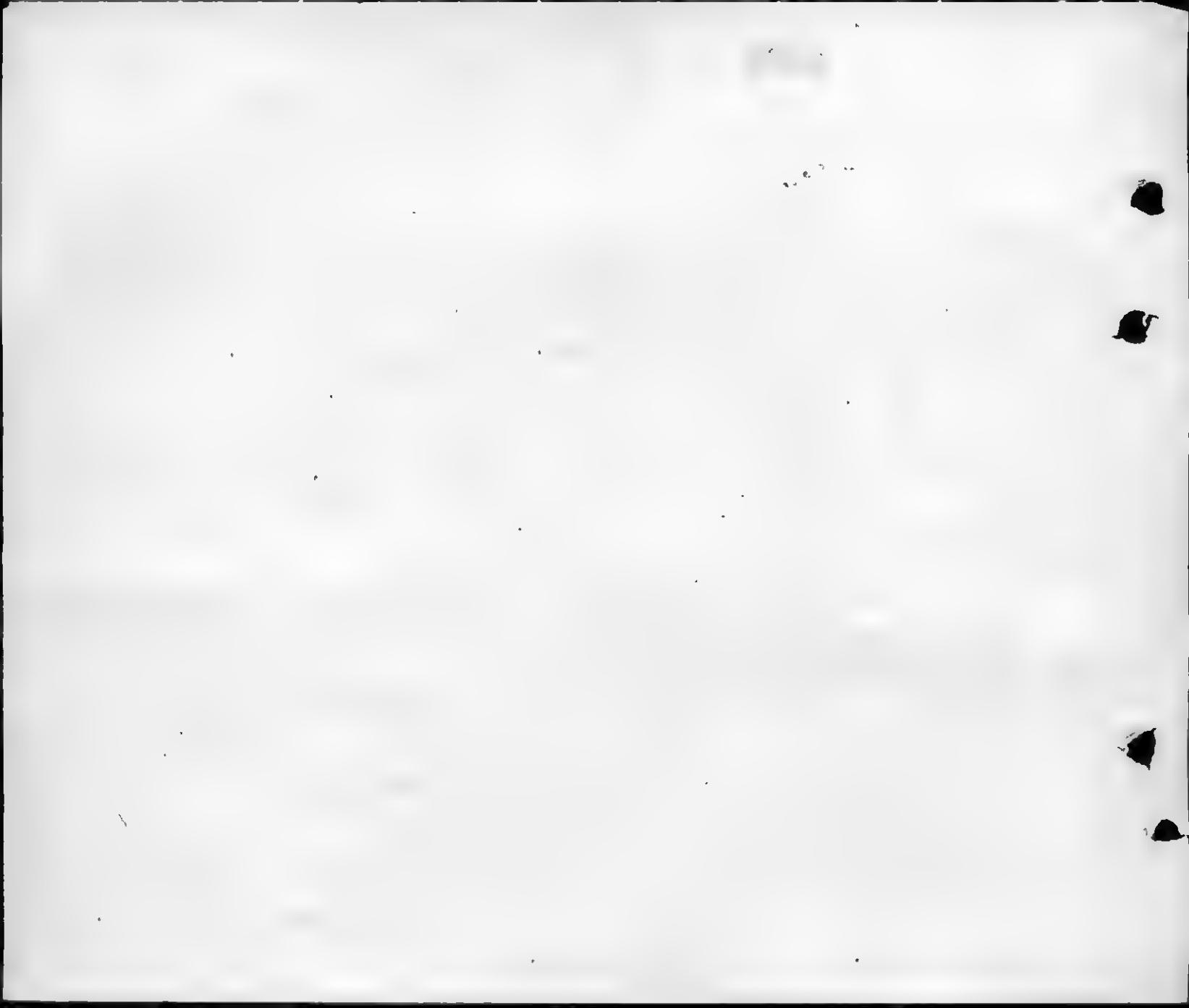
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02373

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 719 Virginia Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 719 Virginia Ave						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM		First HARRY	Middle CLINE	Last 	4. DATE OF DEATH February 26 1961	Month 19	Day 	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 6 1906	9. AGE (In years lost birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. IF UNDER 24 HRS. Hours 	13. IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Airplane Corp.		11. BIRTHPLACE (State or foreign country) Security Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John W. Cline				14. MOTHER'S MAIDEN NAME Rebecca S. Webb				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 314-09-7544		17. INFORMANT Mrs Raoalie Cline 719 Virginia Ave		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH minutes								
416X Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) CHF - VENTRICULAR FAILURE								
DUE TO (c) Rheumatic HEART DISEASE YEARS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4-26-57 to 2-26-61 , that (I) (we) last saw the deceased alive on 2-25-1961 and that death occurred at 12:00 M , from the causes and on the date stated above.								
22a. SIGNATURE <i>D. J. Boyce</i>		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 2-28-61			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/1/61		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Cemetery		23d. LOCATED ON (City, town, or county) (State) Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown - d.						
				25a. REC'D BY REGISTRAR DATE MAR 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2404

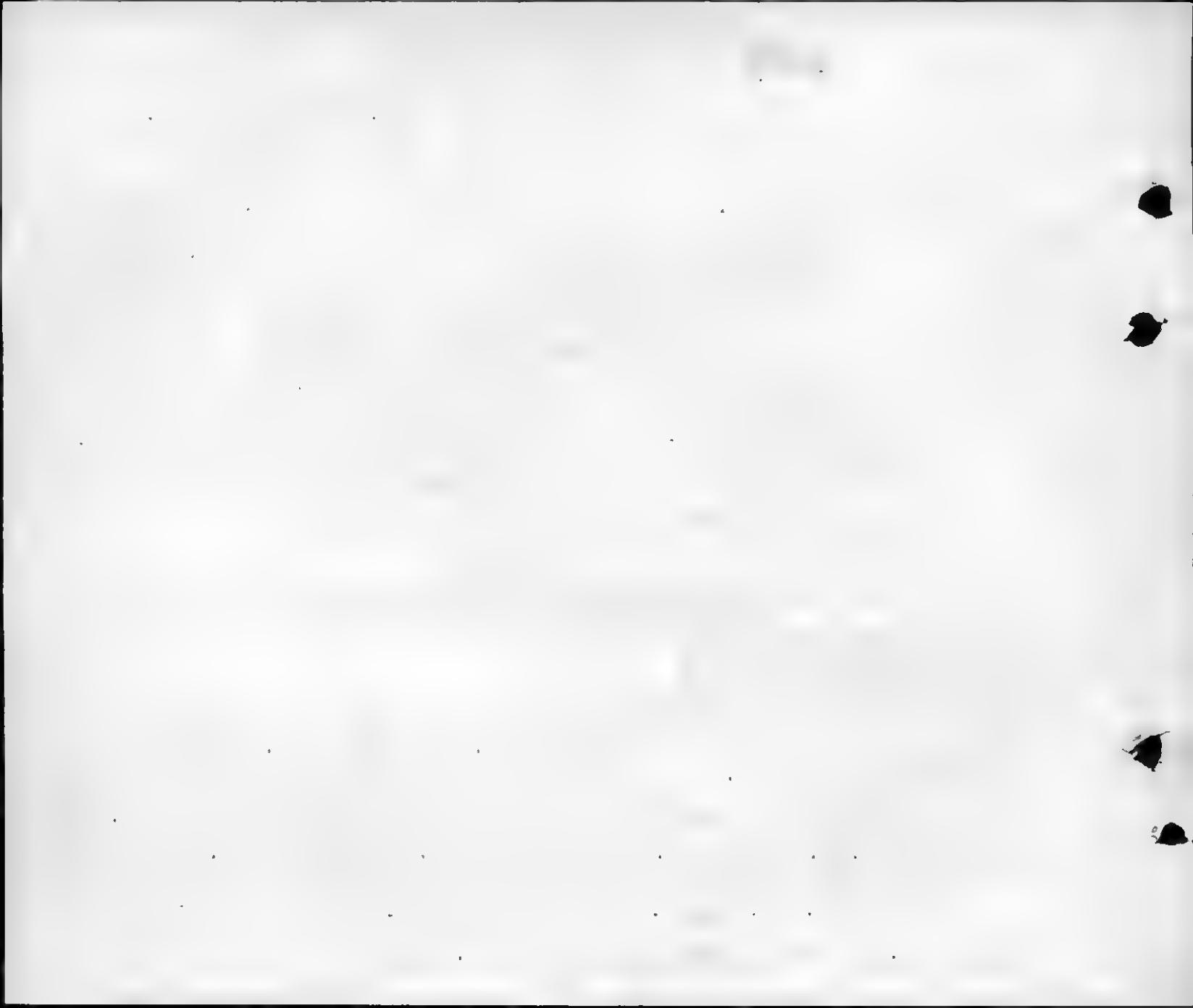
CERTIFICATE OF DEATH

02304

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN 1b 26 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1714 Virginia Ave.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown,	
d. STREET ADDRESS 1714 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Maud	Middle Oliva	Last Coffman
4. DATE OF DEATH	Month Feb.	Day 25	Year 1961
5. SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1885
9. AGE (In years last birthday) 75 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house keeper	11. KIND OF BUSINESS OR INDUSTRY private homes	12. BIRTHPLACE (State or foreign country) Jerome, Virginia
13. FATHER'S NAME Thomas Rinker	14. MOTHER'S MAIDEN NAME Elizabeth Miller	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 205-30-3507		17. INFORMANT Kenneth Coffman, Hagerstown, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17 0 X DUE TO Carcinoma of breast with metastasis to lung		INTERVAL BETWEEN ONSET AND DEATH 3 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Nov. 1 1960 to Feb. 25 1961 that (I) (we) last saw the deceased alive on Feb. 18 1961, and that death occurred at 7:40, from the causes and on the date stated above.		22b DATE SIGNED Feb. 25, 61	
22a SIGNATURE 		MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) E. W. Ditto, Jr.		22d ADDRESS 215 W. Washington St. Hagerstown, M	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF Feb. 28, 61	23c NAME OF CEMETERY OR CREMATORIAL St. Paul Lutheran Cem.	23d LOCATION (City, town, or county) Jerome, Virginia (State)
24 FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 27 '61
			25b REGISTRAR'S SIGNATURE O. L. S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours of the death. Page 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2405

CERTIFICATE OF DEATH

0236

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS RT. #4 HAGERSTOWN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HIRIAM	Middle LEO	Last COLVIN
4. DATE OF DEATH	Month FEBRUARY	Day 8	Year 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1870
9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT COLVIN		14. MOTHER'S MAIDEN NAME ELIZABETH HURT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) NO		16. SOCIAL SECURITY NO. 705-10-1741	
17. INFORMANT MRS. ANNA DALEY		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 hr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Altered state (c) years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) HAGERSTOWN (County) MARYLAND (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Jan 1961, to Feb 8 1961, that (I) (we) last saw the deceased alive on 30 Jan 1961, and that death occurred at 7 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Edgar Goodliffe		22b. DATE 2/11/61	
22c. PHYSICIAN'S NAME (Type) Eldon J. Goodliffe		22d. ADDRESS 115 W Wash. St Hagerstown, Md.	
23a. BURIAL CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/11/61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ROSE HILL CEM.		23d. LOCATION (City, town, or county) HAGERSTOWN (State) MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE W.J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 '61	
		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



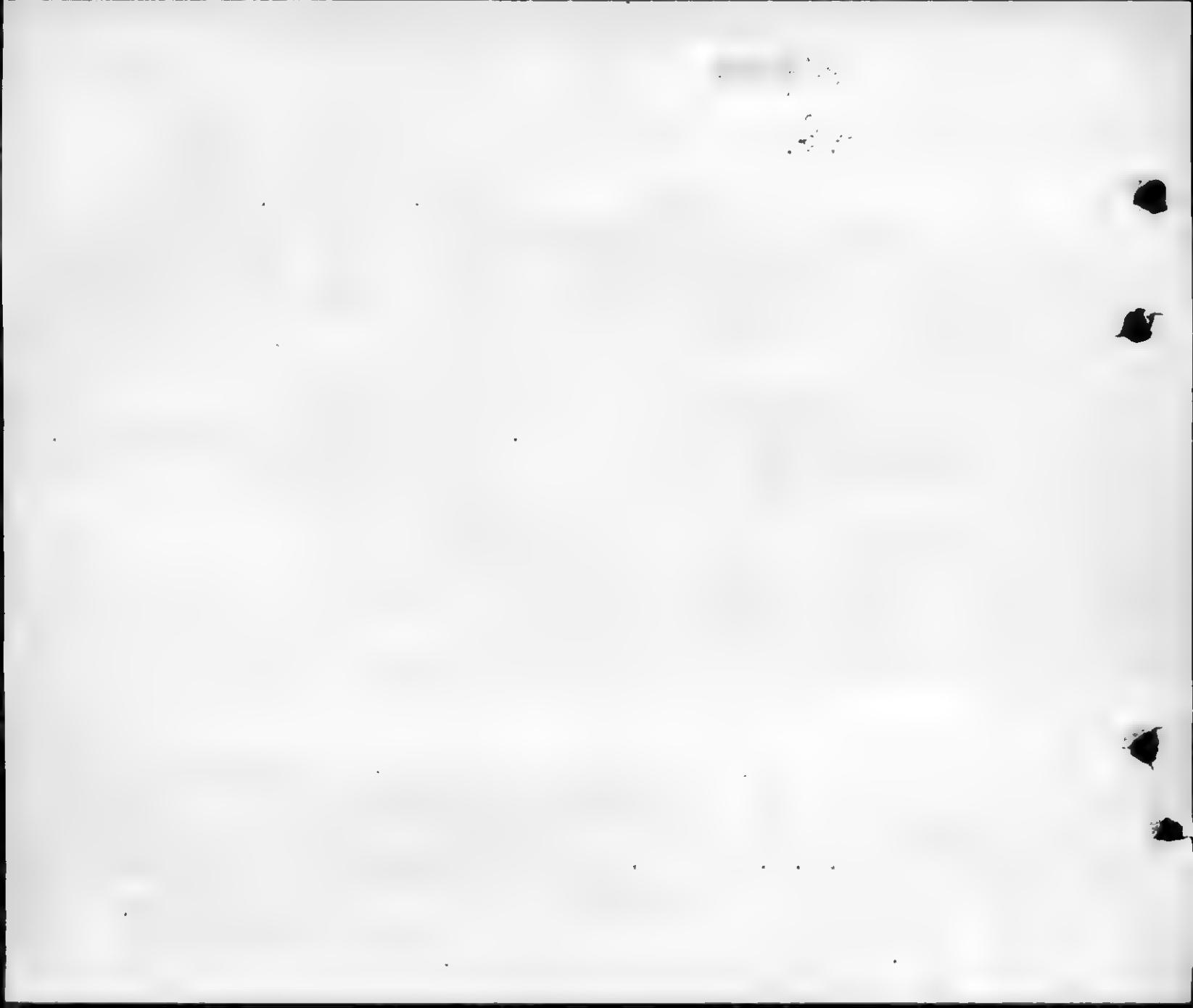
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2406

CERTIFICATE OF DEATH

02362

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 53 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Catherine	Last Cramer
4. DATE OF DEATH	Month February	Day 24	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1887
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Brust		14. MOTHER'S MAIDEN NAME Florence Stahl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ---		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---	
17. INFORMANT Mrs. Rebecca Martin		Address Hagerstown, md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease DUE TO 422.1			
INTERVAL BETWEEN ONSET AND DEATH 5 years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) General Arteriosclerosis DUE TO (c) Mid Thigh Amputation Right Leg DUE TO 5 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown (County) Md. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 12-1-1960 to 2-24-1961 , that (I) (we) last saw the deceased alive on 2-23-1961 , and that death occurred at Hagerstown , from the causes and on the date stated above.			
22a. SIGNATURE J. E. W. Ditto		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.	
22d. ADDRESS Hagerstown, Md.		22e. DATE SIGNED Feb 27, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-26-61	
23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown, Md.	
25a. REC'D. BY REGISTRAR Feb 27, 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

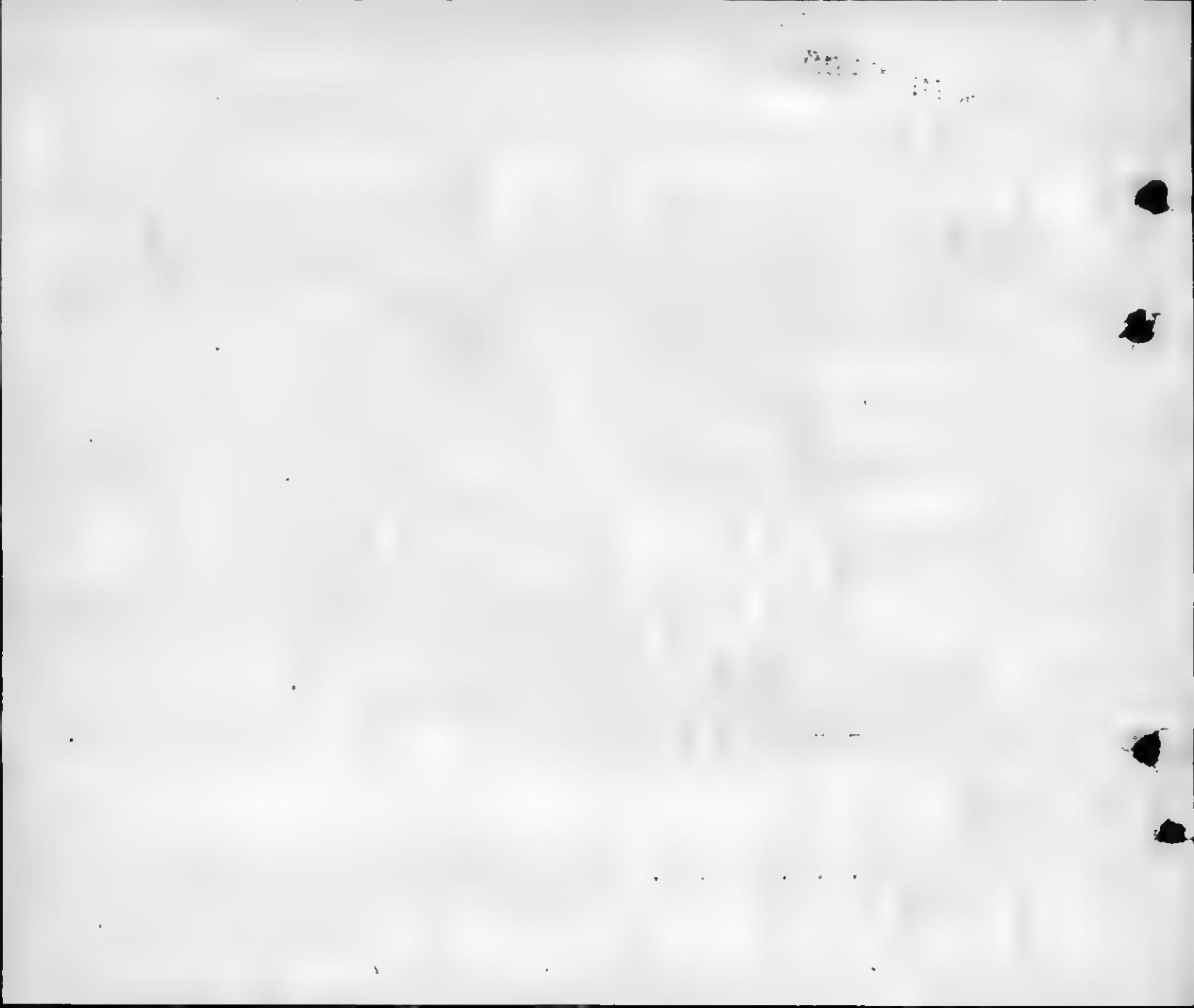
2407 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 42383

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, in the word "pending", in pencil in Item 18. Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 4 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1110 Security Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1110 Security Road				d. STREET ADDRESS 1110 Security Road						
3. NAME OF DECEASED (Type or print) DUANE FRANK DAVIDSON		First	Middle	Last	4. DATE OF DEATH February 24 1961	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 23 1956	9. AGE (In years last birthday) 4 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Frank O. Davidson		14. MOTHER'S MAIDEN NAME Kathleen Dewey								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT None		Address Frank O. Davidson 1110 Security Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation Due To Balls Of Sud In Mouth And										
DUE TO 722.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Larynx										
DUE TO (c)										
INTERVAL BETWEEN ONSET AND DEATH Minutes										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pinned on ground beneath falling cabinet.								
20c. TIME OF INJURY Hour a. m. 11:30		Month, Day, Year 2-21- 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hagerstown, Washington, Md.		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 2-25-61
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/87/61		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Lawn Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash Co Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 28 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Krause				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 112384

2408

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18, Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1705 Oak Hill Ave.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF -DECEASED (Type or print) Mary		First W	Middle Davis
4. DATE OF DEATH 2	Month 22	Day 19	Year 61
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1923
9. AGE (In years at birth) 37 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earl A. Rider		14. MOTHER'S MAIDEN NAME Rose Goldsborough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 216-14-5170	17. INFORMANT John J. Davis	Address Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination following Stab Wound (Knife) INTERVAL BETWEEN ONSET AND DEATH Hour minutes			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Of right Side Of Abdomen Involving Liver.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mother Stabbed With Knife By Son.	
20c. TIME OF INJURY Hour 7:10 p.m.	Month, Day, Year 2-22-1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Hagerstown, Md.	(County) Washington, Md.	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>A. E. Ditto</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-24-61
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2-25-61	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR FEB 28 '61
			24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Kraiss</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

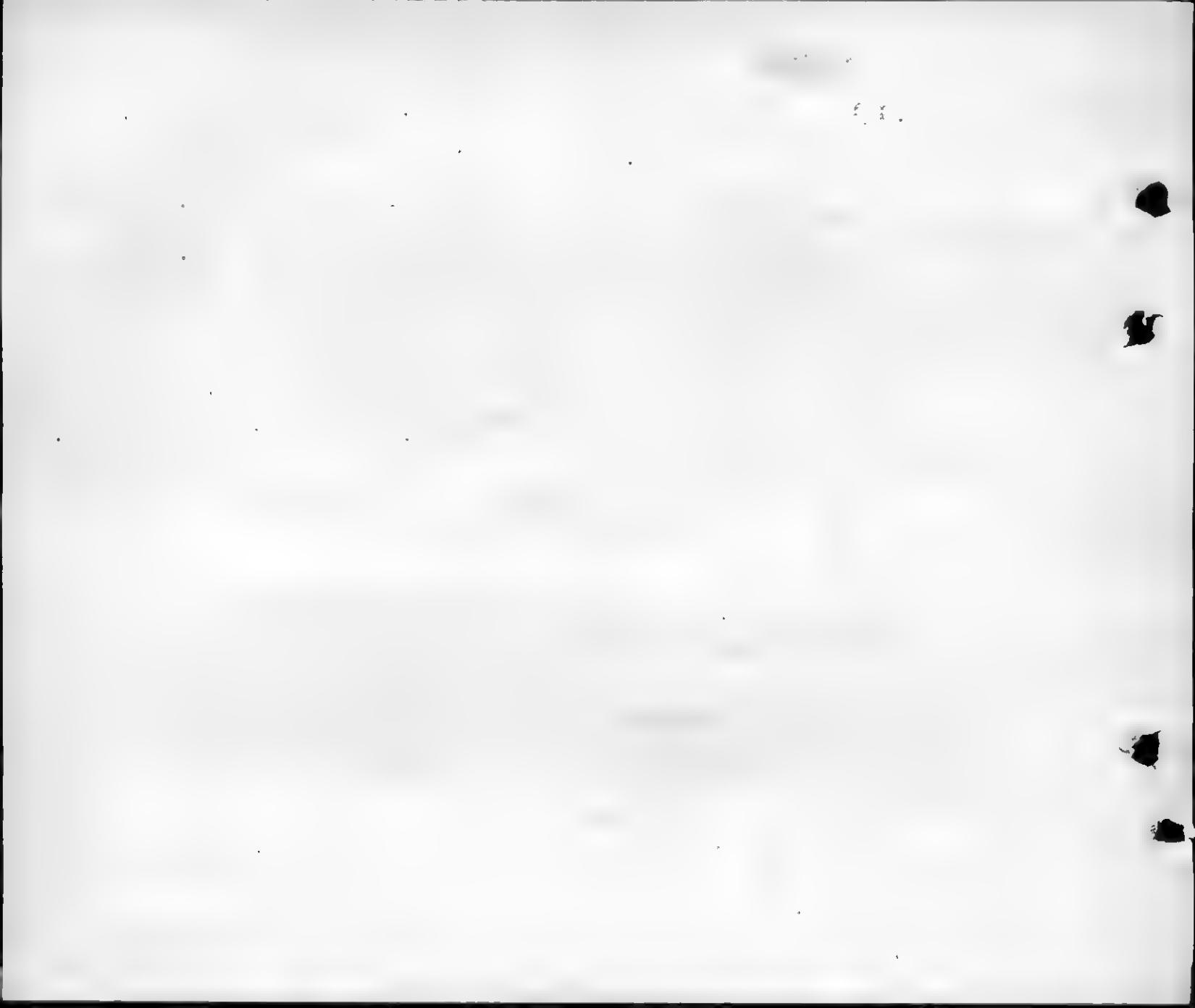
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2409

CERTIFICATE OF DEATH

(1236)

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		b. COUNTY Wash.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 72 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 211 E. Washington St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 E. Washington St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Julia	Middle Diebear	Last Deibert	4. DATE OF DEATH b. L. 10, 1961	Month Month	Day Day	Year Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1888		9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? Hagerstown, Md.		
13. FATHER'S NAME George Warner			14. MOTHER'S MAIDEN NAME Anna Martin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 214-09-7287		17. INFORMANT John C. Deibert, Hagerstown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion of pulmonary infarct</u> INTERVAL BETWEEN ONSET AND DEATH 48 hours DUE TO <u>42</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Adenocarcinoma of breast, right</u> Indefinite								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Adenocarcinoma of breast, right</u>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----						
20c. TIME OF INJURY Hour a. m. <u>4</u> p. m. <u>4</u>		20d. INJURY OCCURRED While <u>at work</u> Not while <u>at work</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>February 10, 1961</u> death <u>October 1967</u> , that (I) (we) last saw the deceased alive on <u>February 10, 1961</u> and that death occurred at <u>2:10 A.M.</u> from the causes and on the date stated above.								
22a. SIGNATURE <u>Robert F. Keadle</u>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED FEB 14 '61	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.		22d. ADDRESS 318 North Potomac Street, Hagerstown						
23a. BUR. A. CREMATION REMOVAL (Specify) DURIAL		23b. DATE THEREOF Feb. 13, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Cavetown Cemetery		23d. LOCATION (City, town, or county) Cavetown, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		25a. REC'D. BY REGISTRAR FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur J. Thrall		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

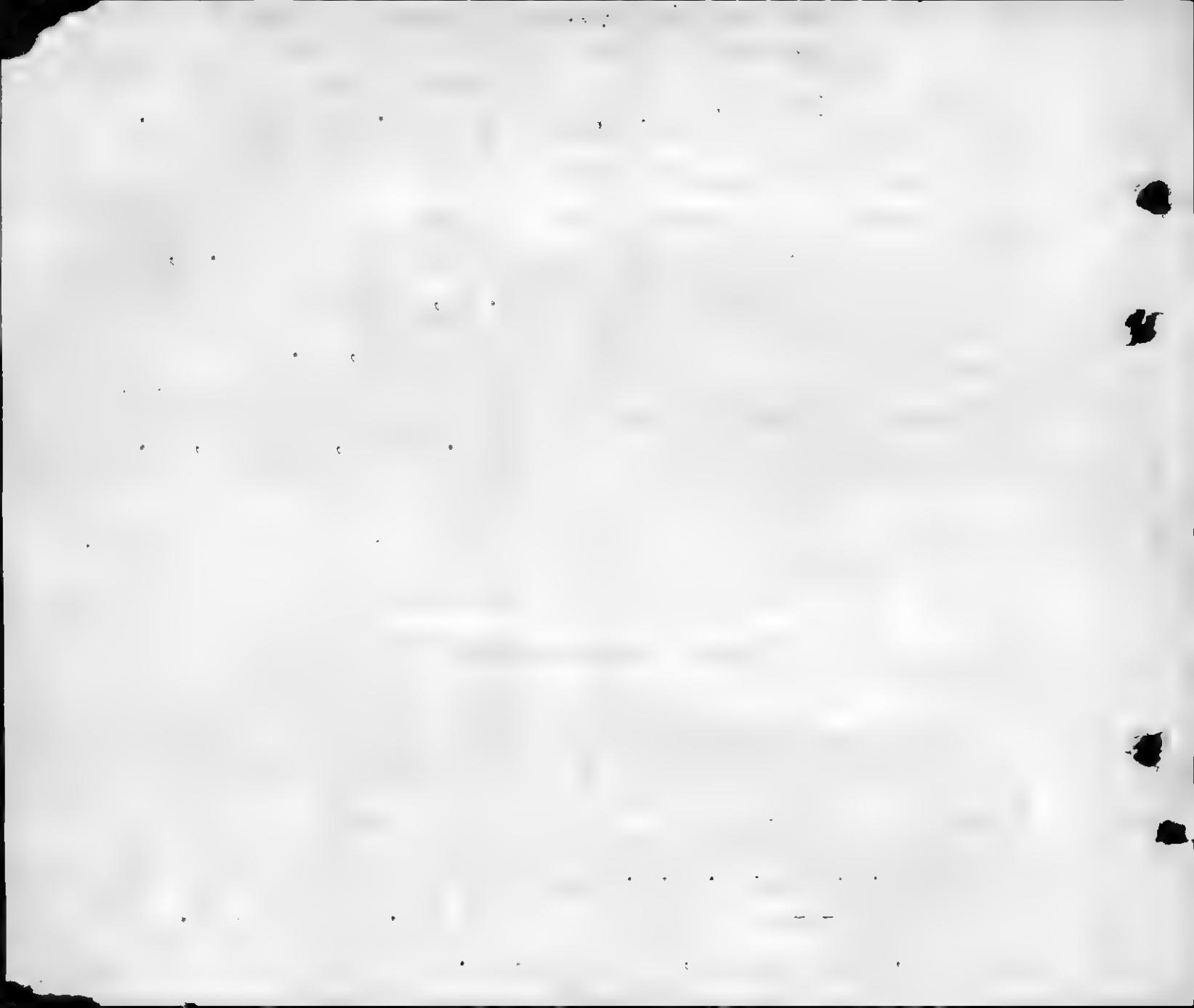
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. ATSM(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No 0236

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cavetown			c. LENGTH OF STAY IN 1b 19 years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cavetown		
3. NAME OF DECEASED (Type or print) Genevieve			First Genevieve	Middle Catherine	Last Eccard
4. DATE OF DEATH Feb. 2, 1961			Month Feb.	Day 2	Year 1961
5. SEX female			6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Chewsville, Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Robert Glenn			14. MOTHER'S MAIDEN NAME Nelia Cauliflower		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		
17. INFORMANT Glenn W. Eccard, Cavetown, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0			DUE TO INTRAVENTRICULAR HEMORRHAGE few hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			DUE TO GLIOMA OF BRAIN, left parieto-occipital 1 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) E. W. Ditto, Jr., M.D.			DATE SIGNED 2-2-61		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-4-61		22c. NAME OF CEMETERY OR CREMATORIAL Cavetown Reformed Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 6 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 File No. 23-1-61 et

CERTIFICATE OF DEATH

Reg. Dist. No. 1238

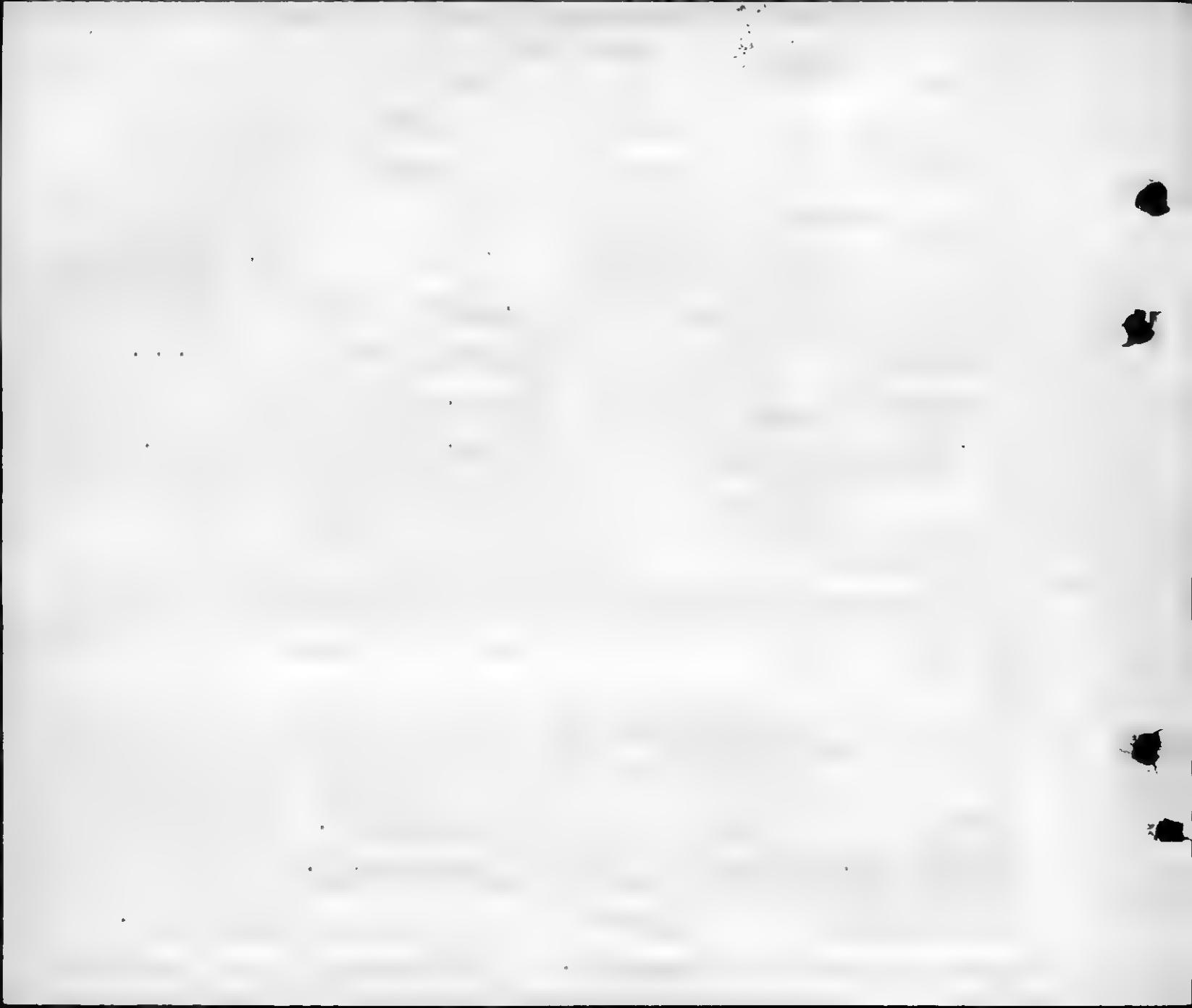
2411

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Washington</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown, Md.</i>		c. LENGTH OF STAY IN 1b <i>En route</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Highfield</i>		d. STREET ADDRESS <i></i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>M.U.A. Washington County Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Helen Harbaugh</i>		First <i>Helen</i>	Middle <i>Harbaugh</i>	Last <i>Eyler</i>	4. DATE OF DEATH <i>Feb. 23 1961</i>	Month <i>Feb.</i>	Day <i>23</i>	Year <i>1961</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct. 9, 1891</i>	9. AGE (In years lost birthday) yrs. <i>69</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cascade, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Luke Harbaugh</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Dilk</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Thomas O. Eyler</i>		Address <i>Highfield, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Acute myocardial infarction</i>		VENTRICULAR FIBRILLATION		INTERVAL BETWEEN ONSET AND DEATH <i>moments</i>		DUE TO <i>Coronary arteriosclerosis</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>	(County) <i></i>	
21. I certify that I attended the deceased from _____, 19____, to Feb. 23, 1961, that I last saw the deceased alive on Feb. 23, 1961, and that death occurred at 2:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>John C. Stouffer</i>						ADDRESS (Street, city or town, state) <i>Hagerstown, Md.</i>		
PHYSICIAN'S NAME (Type) <i>John C. Stouffer</i>						DATE SIGNED <i>2/23/61</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/26/61</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Waynesboro, Penna.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Stouffer</i>		ADDRESS <i>Waynesboro, Pa.</i>		24a. REC'D BY REGISTRAR <i></i>		24b. REGISTRAR'S SIGNATURE <i>John C. Stouffer</i>		
				DATE <i>FEB 27 '61</i>				

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2412

CERTIFICATE OF DEATH

309

02388

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

3 Days

d. NAME OF HOSPITAL (If not in hospital, give street address)

FOR INSTITUTION

Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. STREET ADDRESS

117 South Mont Vallie Ave

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
February
Year
1961

S. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

73 yrs.

10. UNDER 1 YEAR

11. UNDER 24 HRS

Months
Days
Hours
Min.

Male

White

WIDOWED

DIVORCED

January 23 1888

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Merchant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hagerstown Wash Co Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Alexander Feigley

14. MOTHER'S MAIDEN NAME

Katie Bowers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

19-12-0516 Mrs Cleta L. C. Feigley 117 So Mont Vallie Hagerstown Md

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4-29

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Left Ventricular Heart Failure 6 yrs

Arterio-Sclerotic Heart Disease

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION STATED IN PART I (a)

None

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour o. m.

19

p. m.

20d. INJURY OCCURRED

White Not white

at work of work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1/20/61 to 1/23/61, that (I) last saw the deceased alive on 1/20/61 and that death occurred 1/23/61 M. from the causes and on the date stated above.

22. SIGNATURE

J. T. Beachley M.D. ATTENDING PHYSICIAN MED. DIRECTOR STAFF PHYS.

22b. DATE
SIGNED

Feb 23 '61

22c. PHYSICIAN'S
NAME (Type)

J. T. Beachley Hagerstown, Md.

23a. BURIAL CREMATION, REMOVAL (Specify)

Burial 3/1/61

23b. DATE THEREOF

Rose Hill Cemetery

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

25a. LOCATION (City, town, or county)

Hagerstown Wash Co Md

25b. REC'D BY REGISTRAR

DATE FEB 23 '61

25b. REGISTRAR'S SIGNATURE

ADDRESS

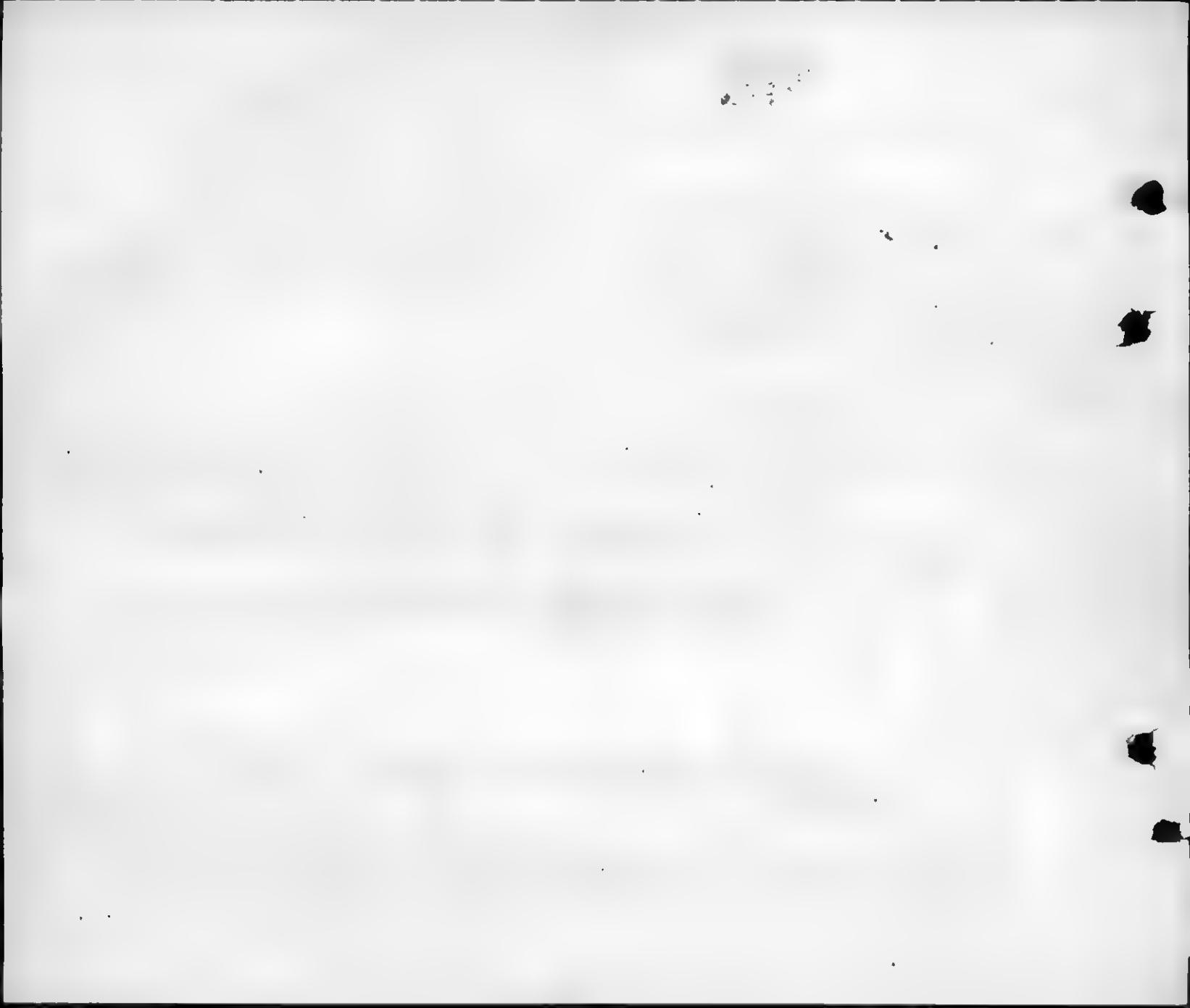
Andrew L. Corrigan Hagerstown Md.

DATE FEB 23 '61

REGISTRAR'S SIGNATURE

ADDRESS

8-1-2 Hagerstown Md.



1
FOR STATE
HEALTH DEPT.

4
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02383

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. LENGTH OF STAY IN lb e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) GEORGE EDWIN FETTER JR	4. DATE OF DEATH FEBRUARY - 9 - 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19 - 1954	9. AGE (In years last birthday) <input type="checkbox"/> IF UNDER 1 YEAR 6 months <input type="checkbox"/> IF UNDER 24 HRS. 20 days <input type="checkbox"/> Hours <input type="checkbox"/> min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) WASH. Co. MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE EDWIN FETTER SR	14. MOTHER'S MAIDEN NAME DOROTHY REISMAN Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or date of service NO	16. SOCIAL SECURITY NO None	17. INFORMANT GEORGE E. FETTER KEDYSVILLE MD. R.I		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
Caught beneath falling roof of Wood shingled				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Caught beneath falling roof of wood shingled			
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p.m. 2-9 1961	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Kedysville Washington	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE J. E. FETTER	CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) J. E. FETTER	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF FEB. 12 1961	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Zion CEMETERY	22d. LOCATION (City, town, or country) Locust GROVE WASH. Co. MD.	(State)
23. FUNERAL DIRECTOR John E. Best	24a. REC'D. BY REG. STRR FEB 14 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02390

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 26 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tackson Convalescent Home		d. STREET ADDRESS 155 S. Potomac St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Fiery	4. DATE OF DEATH	Month February	Day 12	Year 1961
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1971	9. AGE (In years last birthday) 8 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) State Line Pa.		12. CITIZEN OF WHAT COUNTRY? Hagerstown, Md.	
13. FATHER'S NAME Christian Stotler			14. MOTHER'S MAIDEN NAME Lydia A. Dahoff			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Albert F. Fiery		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiac vascular disease 422 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) General senility DUE TO DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1946 to 1961, that (I) (we) last saw the deceased alive on 2.10.61, and that death occurred at 2.12.61, A.M., from the causes and on the date stated above.							
22a. SIGNATURE S. Earl Young M.D.		22b. ATTENDING M.D. PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2/13/61			
22c. PHYSICIAN'S NAME (Type) S. Earl Young M.D.		22d. ADDRESS 148 N. Potomac St., Hagerstown, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) 2-14-61		23b. DATE THEREOF 2-14-61		23c. NAME OF CEMETERY OR CREMATORIUM Funkstown Cemetery		23d. LOCATION (City, town, or county) Funkstown, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott P. Minnick & Son				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 15 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0239

2415

1. PLACE OF DEATH

e. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

MARYLAND

c. LENGTH OF STAY IN lb

57 years

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

CHARLES

BRITTON

FLEGAL

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

May 17, 1874

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retire Brakeman

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (County & State, or foreign country)

Phillipsburg, Penn.

13. FATHER'S NAME

George W. Flegal

14. MOTHER'S MAIDEN NAME

Margaret Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

705-10-5262

Mrs. Ada M. Flegal Hagerstown, Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary occlusion

Coronary artery sclerosis

Generalized arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

2 day

Cause

Cause

MEDICAL CERTIFICATION

20c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Excessive laboral performance

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour
p.m.

Month

Day

Year

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

Sept. 17, 1947 to Feb. 16, 1961, that (I) (we) last

saw the deceased alive on Feb. 16, 1961, and that death occurred

6:00 A.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

L. H. Packer, Jr.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

145 W. Washington St

Hagerstown, Md.

2/17/61

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

2/19/1961

23b. DATE THEREOF

Rose Hill Cemetery

23d. LOCATION (City, town or county)

Hagerstown,

(State) Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Suter - Rouzer Funeral Home

R. Franklin, Owner

ADDRESS

Hagerstown, Md.

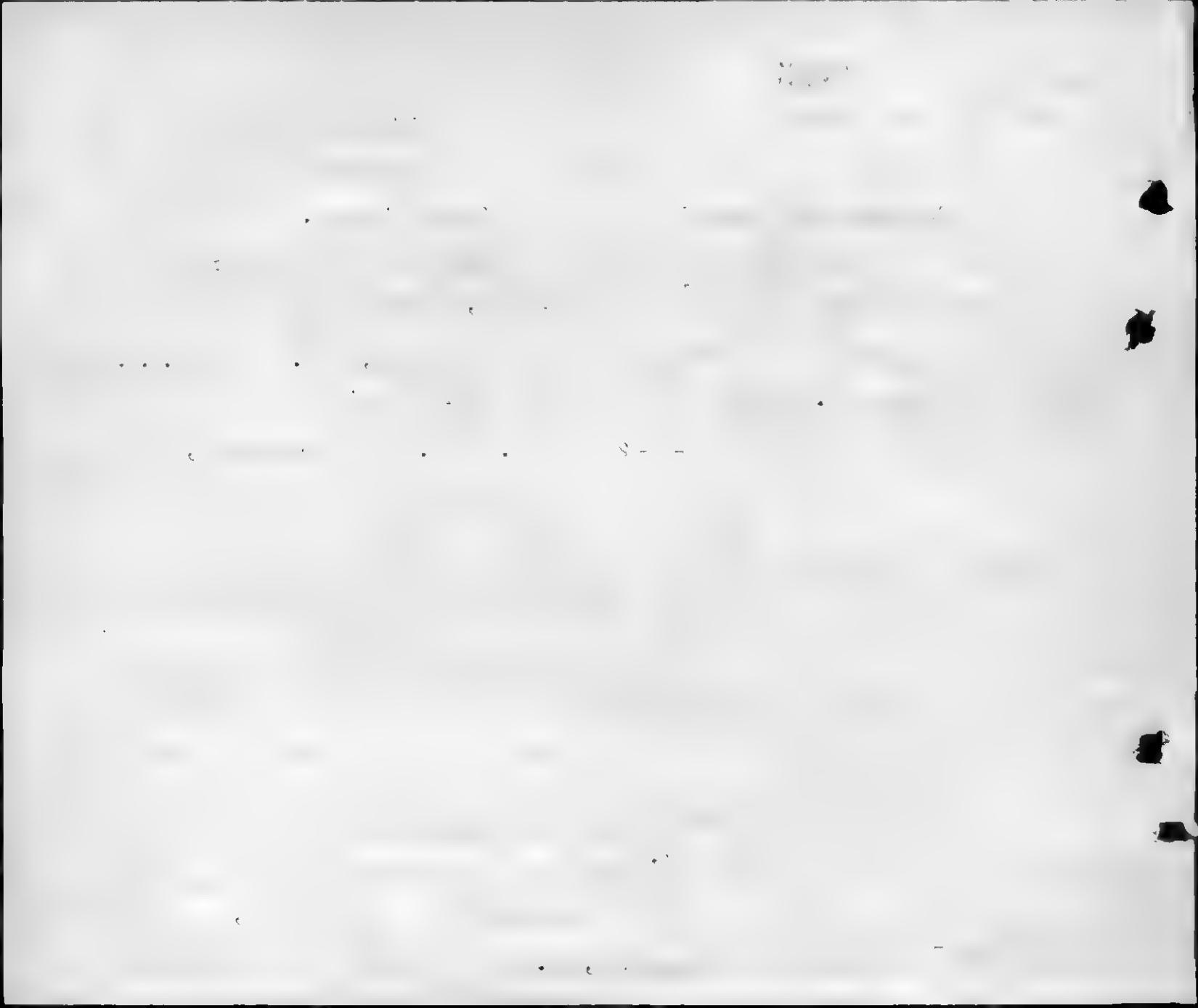
25e. REC'D. BY REGISTRAR

FEB 23 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(12392)

1. PLACE OF DEATH		2416		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
a. COUNTY		MARYLAND		a. STATE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
Boonsboro		20 yrs.		Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Hagerstown		Washington	
Reeder Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
3. NAME OF DECEASED (Type or print)		First Middle Last		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Aaron		Wesley		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE		Month Day Year	
Male		White		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		10c. BIRTHPLACE (County & State, or foreign country)	
Farmer		Agriculture		11. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		USA	
Aaron W. Gallion		Magdelina Black		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Mr. David Gallion Sr. Boonsboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. WAS AUTOPSY PERFORMED?		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1/2 hours	
S 3 1 X		DUE TO		7 years -	
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause (b),		(b)		Cerebral hemorrhage	
} stating the underlying cause (c),		(c)		Generalized arteriosclerosis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II, of item 18)		Crysp. in heart for life	
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour e.m. p.m.		While at work		20f. (City or town) (County) (State)	
19		<input type="checkbox"/> <input type="checkbox"/>		10:25 - 1961, to 11:28 - 1961	
21. I certify that (I) (this hospital) attended the deceased from 11:25 - 1961, to 11:28 - 1961, that (I) (we) last saw the deceased alive on 11:28 - 1961, and that death occurred at 12PM, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		M D ATENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial		3/3/61		23d. LOCATION (City, town or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Rest Haven Funeral Chapel		Hagerstown, Md.		DATE MAR 6 '61	
W. H. G. 1961		Arthur L. Thomas		Signature	



may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

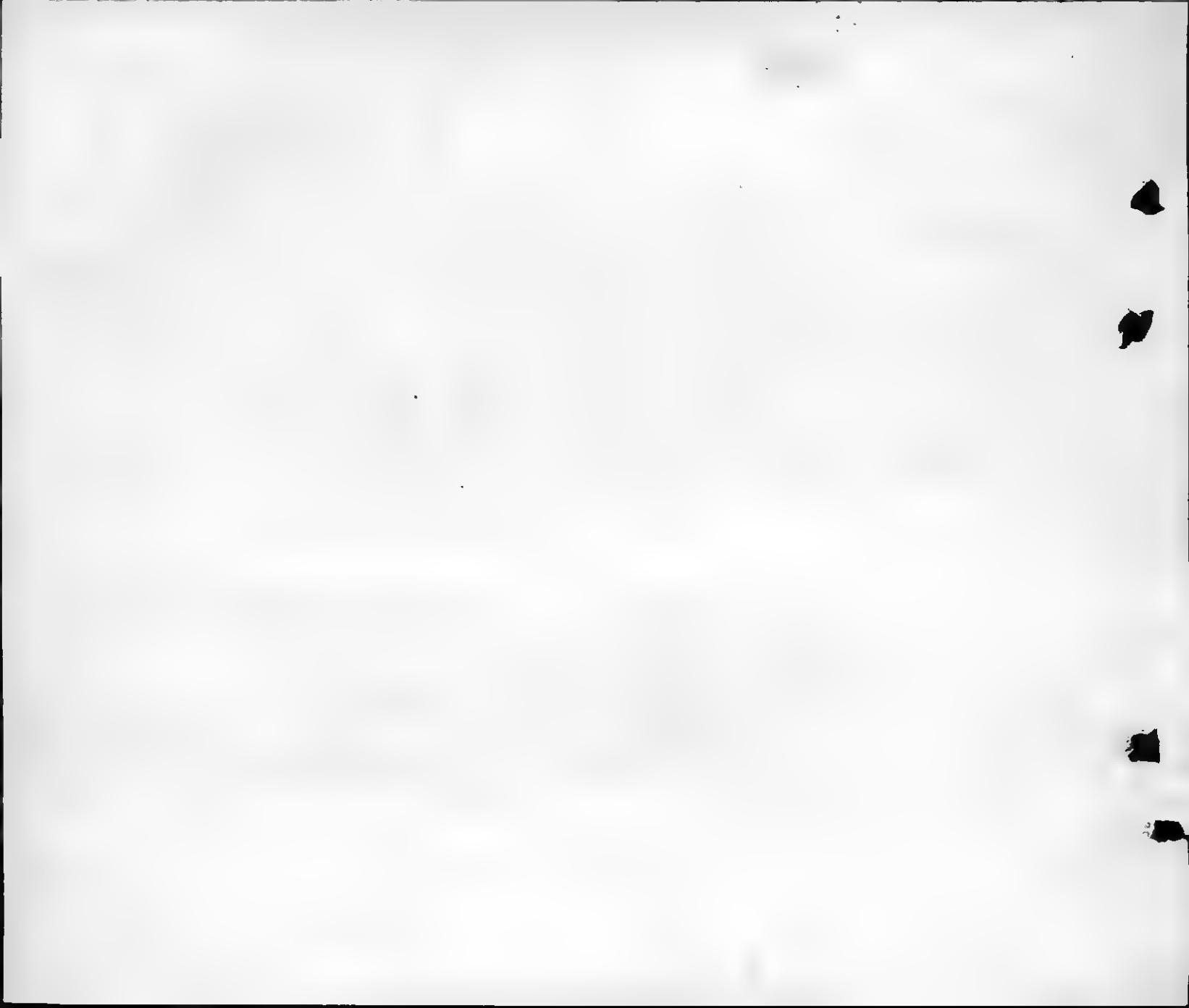
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2417

1239

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Washington		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Leitersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Leitersburg, Md.		Leitersburg, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
DAVID		W.	GOSSARD
4. DATE OF DEATH		Month	Day
Feb.		19	61
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	B. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Moulder Organ - Manuf. Organs.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
David		Henrietta Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
450		205-09-05 Mrs. Allen Baker - Leitersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Congenital heart failure	
(b)		1 yr.	
DUE TO		Severe arteriosclerosis	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 14, 1961, to Feb 1, 1961, that (II) (we) last saw the deceased alive on Feb 14, 1961, and that death occurred at 10 AM, from the causes and on the date stated above.			
22a. SIGNATURE		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
David R. Hess, M.D.		51/21/61, George, Pa.	
23a. BURIAL OR CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
B.		2/5/61	
23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county) (State)	
Broadfording Cem.		Wash. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
A. G. Mennich - Greencastle		Pa.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE FEB 7 '61		C. G. Mennich	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death
DR. HESS
SMITHS (301) 112334

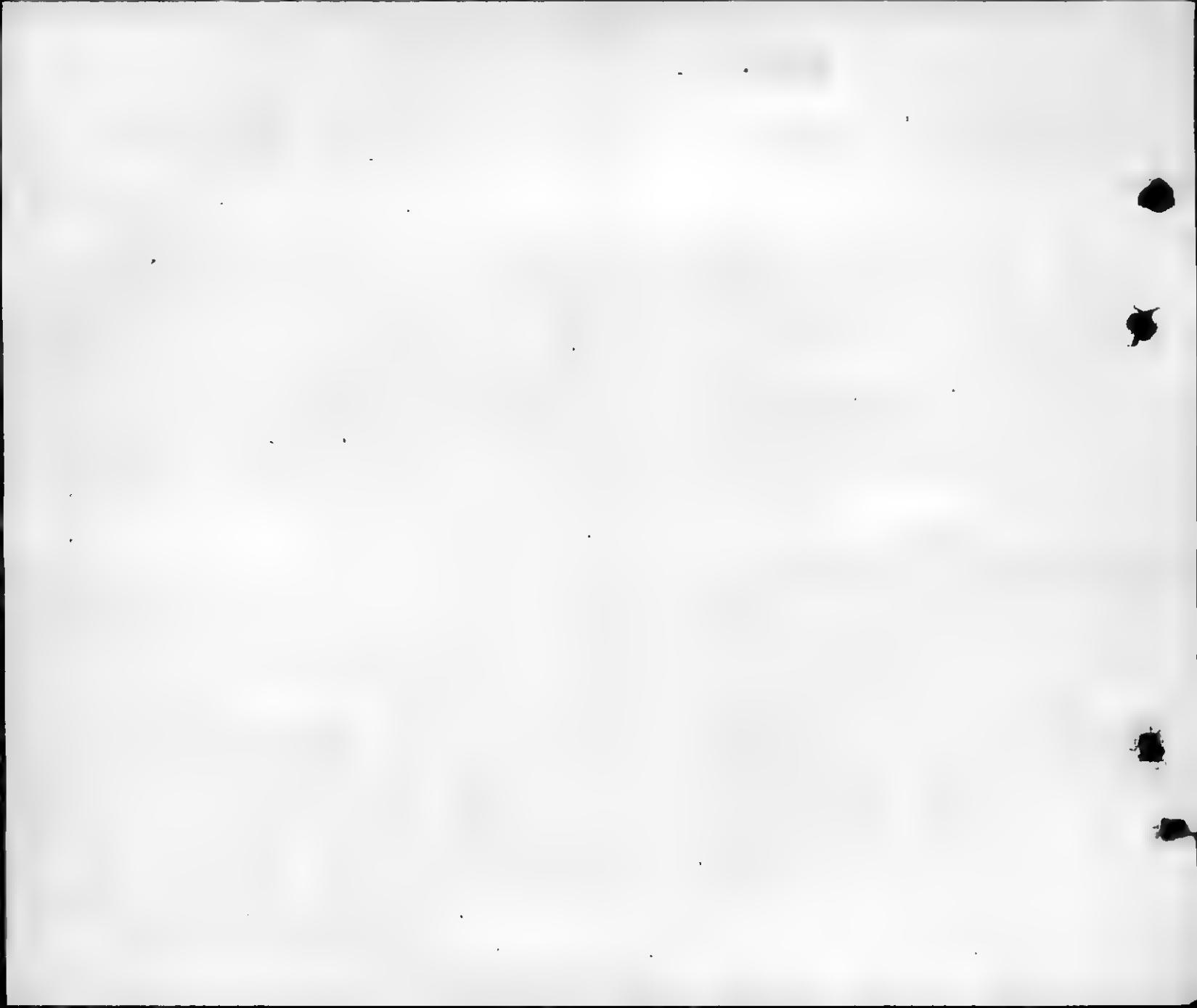
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2418

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN		c. LENGTH OF STAY IN lb MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FUNKSTOWN		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
3. NAME OF DECEASED (Type or print) MAGGIE D. GROSSNICKLE		4. DATE OF DEATH FEBRUARY 20. 1961	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 14. 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ED. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHAN ECCRARD		14. MOTHER'S MAIDEN NAME CHARLOTTE GAYER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. EDWIN MOSER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure DUE TO 150 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterio-occlusive vascular disease DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 14 hr.	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Renal Failure	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-21-56 to 2-20-51 , 19, that (I) (we) last saw the deceased alive on 2-22 , 1951, and that death occurred at 2:30 P.M. from the causes and on the date stated above		22b. DATE SIGNED	
22a. SIGNATURE Charles F. Hess		22b. ADDRESS 5117 1/2 St., W. H. 2-1111	
22c. PHYSICIAN'S NAME (Type) C. F. Hess, M.D.		22d. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 23. 1961	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BEAVER CREEK CEMETERY		23d. LOCATION (City, town, or county) (State) BEAVER CREEK WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Barb.		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

2419

CERTIFICATE OF DEATH

02395

1. PLACE OF DEATH a. COUNTY <i>Washington Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		b. COUNTY <i>Washington</i>	
c. LENGTH OF STAY IN 10 <i>years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>745 Spruce St.</i>		d. STREET ADDRESS <i>745 Spruce St.</i>	
3. NAME OF HOSPITAL (Type or print)	First <i>Mary</i>	Middle <i>Ellen</i>	Hammersla
4. DATE OF DEATH <i>Last</i>	Month <i>Feb</i>	Day <i>2</i>	Year <i>1961</i>
5. SEX <i>W</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 26, 1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Franklin Co., Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Christopher Hoyer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Edmundson</i> Address <i>Mrs. Jane Shatz, Clifton Springs, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>—</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>+ 22</i> DUE TO Conditions, if any, which give rise to immediate cause (b) (c), stating the underlying cause last. <i>Arteriosclerosis Generalized</i>		INTERVAL BETWEEN ONSET AND DEATH Min <i>yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arthritis Generalized.</i>		yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>
20f. (City or town) <i>—</i>		(County) <i>—</i> (State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from 19.57 to Feb 2, 1961, that (I) (X) last saw the deceased alive on Feb 2, 1961, and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Louis G. Graff, M.D.</i>		22b. DATE SIGNED <i>2/2/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Louis G. Graff, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>119 E. Antietam St.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/5/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln</i>		23d. LOCATION (City, town or county) <i>Chambersburg, Pa.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert P. Darlow</i>		25a. REC'D BY REGISTRAR <i>FEB 6 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Foran</i>		(State) <i>Pa.</i>	

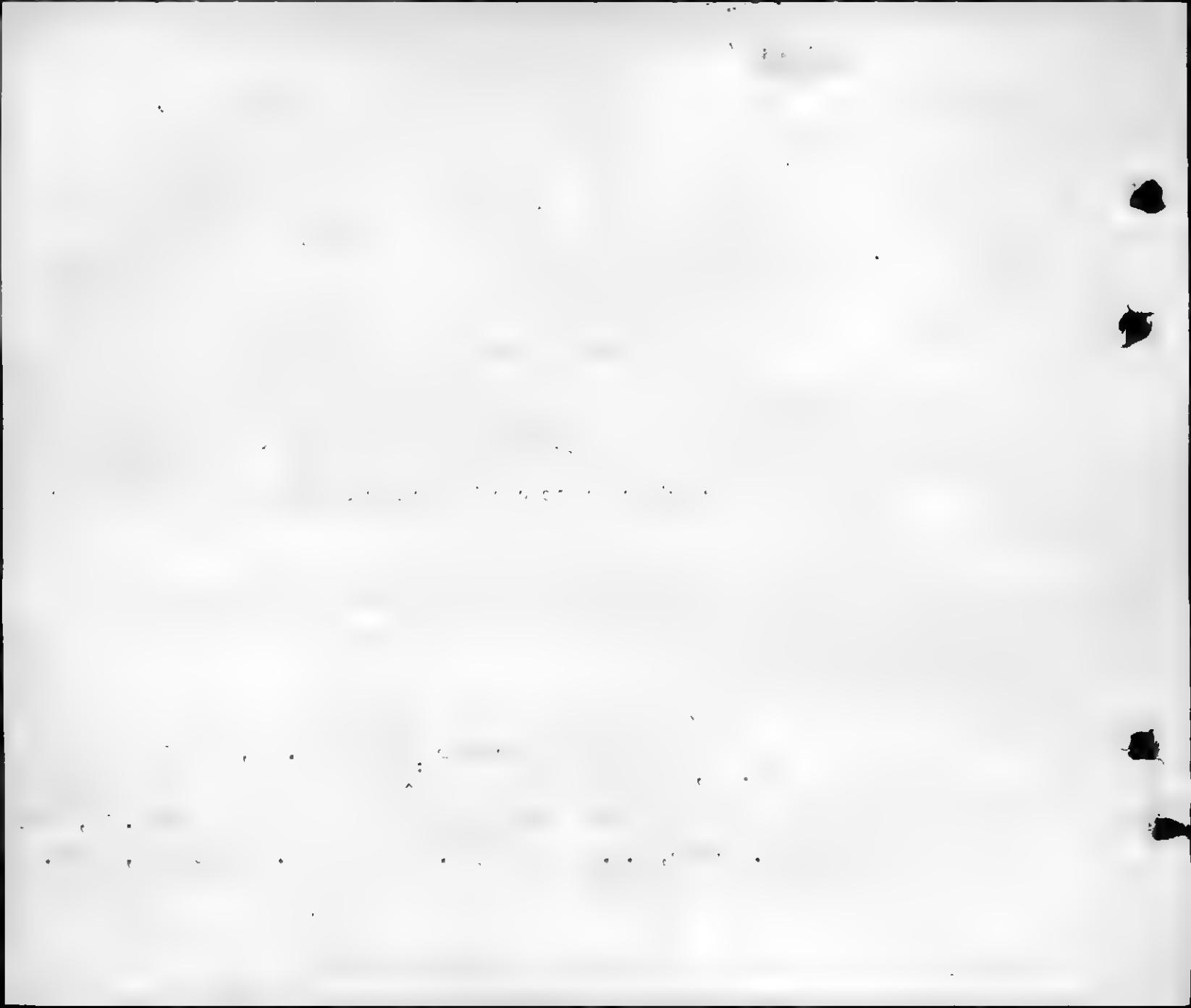


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1239.

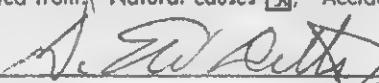
1. PLACE OF DEATH a. COUNTY <i>Wash.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL (If not in hospital, give street address) ORNITHOTON <i>Wash. Co. Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>State Line</i>	
3. NAME OF DECEASED (Type or print) <i>STANLEY W. HARTLE</i>		First <i>W</i>	Middle <i></i>
		Last <i></i>	4. DATE OF DEATH <i>Feb 14</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 19, 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>near State Line, Md.</i>
13. FATHER'S NAME <i>Webster Hartle</i>		14. MOTHER'S MAIDEN NAME <i>Emmelia Brumbaugh</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>W</i>		16. SOCIAL SECURITY NO.	INFORMANT <i>Mrs. Franklin Myers</i>
			Address <i>RD 3 Wayne Station, Pa.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Many years</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>+22.01</i>			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>December 1955</i> to <i>Feb. 14, 1961</i> that (I) (not last saw the deceased alive on <i>Feb. 14, 1961</i> and that death occurred at <i>11:25 AM</i> M. from the causes and on the date stated above.		22b. DATE SIGNED <i>Feb. 14, 1961</i>	
22a. SIGNATURE <i>William C. Brewer, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. ADDRESS <i>359 E. Baltimore St. Greencastle, Penna.</i>	
23a. BURIAL OR CREMATION REMOVED (Specify) <i>2.</i>		23b. DATE THEREOF <i>2/18/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Beautiful View Cem. Wash. Co. Md.</i>
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <i>A. E. Mummich - Greencastle Pa.</i>	
25a. REC'D BY REGISTRAR DATE <i>Feb 17 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Carrie E. Knapp</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 0238

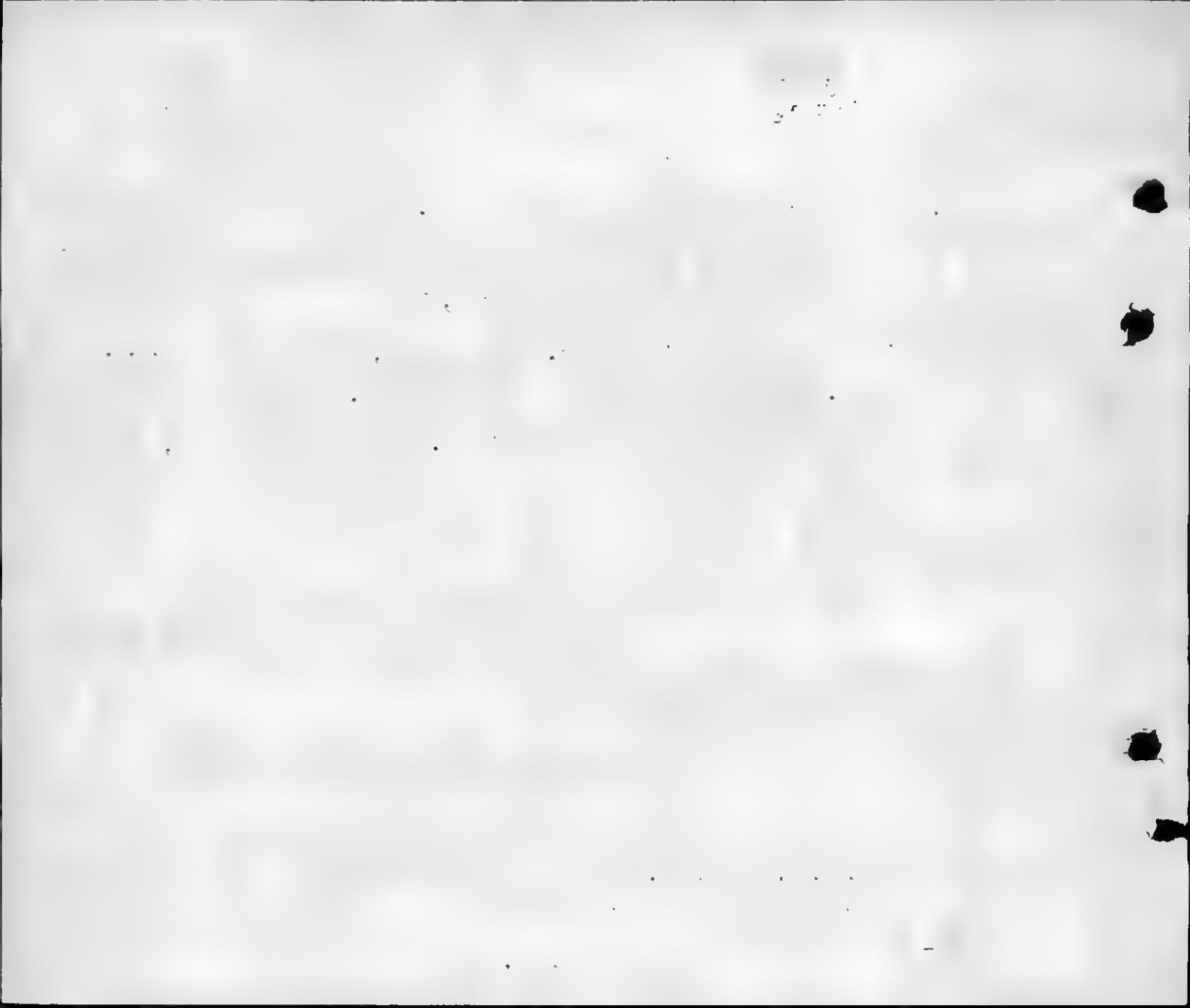
2421

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 336 S. Potomac Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) LAWSON PAUL HAWTHORNE		4. DATE OF DEATH February	Month Day Year 28 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1903
9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Maintenance worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Co.	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry F. Hawthorne		14. MOTHER'S MAIDEN NAME Gertrude F. Wilkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT William H. Hawthorne Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, Severe DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE 		DATE SIGNED 3-1-61	
EXAMINER'S NAME (Type) Dr. W. H. Dilley, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/1961	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Buster - Rouzer Funeral Home R. Jean Allen, Jr.		24a. REC'D BY REGISTRAR DATE MAR 3 '61	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If only delay is necessary, please execute the certificate, write "Pending" in pencil in item 18. Give Pages 1, 2, or 3 to the funeral director. Page 5 may be used for your files. Forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)5
5M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0239

2422

PLACE OF DEATH
 a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

FUNKSTOWN

c. LENGTH OF STAY IN lb

LIFE

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

NO. 40 FREDERICK ROAD

3. NAME OF DECEASED
 (Type or print)

First: FLORENCE
 Middle: VIRGINIA
 Last: HERB.

5. SEX

WHITE

6. COLOR OR RACE

WIDOWED

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

DIVORCED

APRIL 28 1868

92

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

FUNKSTOWN

12. CITIZEN OF WHAT COUNTRY?

WASH. D.C. U.S.A.

13. FATHER'S NAME

OLIVER ISENINGER

14. MOTHER'S MAIDEN NAME

AMANDA MOSER

Address

40 FREDERICK ROAD

FUNKSTOWN MD

INTERVAL BETWEEN
 ONSET AND DEATH

2 months

years.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
 (Yes, no, or unknown)

None

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MRS. ETHEL HARP

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Generalized Arteriosclerosis

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

None.

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

20d. INJURY OCCURRED

While at work

Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 6, 1960, to Feb. 15, 1961, that (I) (we) last saw the deceased alive on Feb. 14, 1961, and that death occurred at 7 A.M., from the causes and on the date stated above.

22a. SIGNATURE

R.A. Bell, M.D.

22b. DATE SIGNED

Feb. 17, 1961.

22c. PHYSICIAN'S NAME (Type)

R.A. Bell, M.D.

22d. ADDRESS

Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

FEB 18 1961

23c. NAME OF CEMETERY OR CEMATORIAL

FUNKSTOWN CEMETERY

23d. LOCATION (City, town, or county) (State)

FUNKSTOWN WASH. D.C. U.S.A.

24. FUNERAL DIRECTOR'S SIGNATURE

John E. Burt

ADDRESS

Boonsboro MD

25a. REC'D BY REGISTRAR

DATE FEB 23 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be examined within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, or in any event within 72 hours of death.

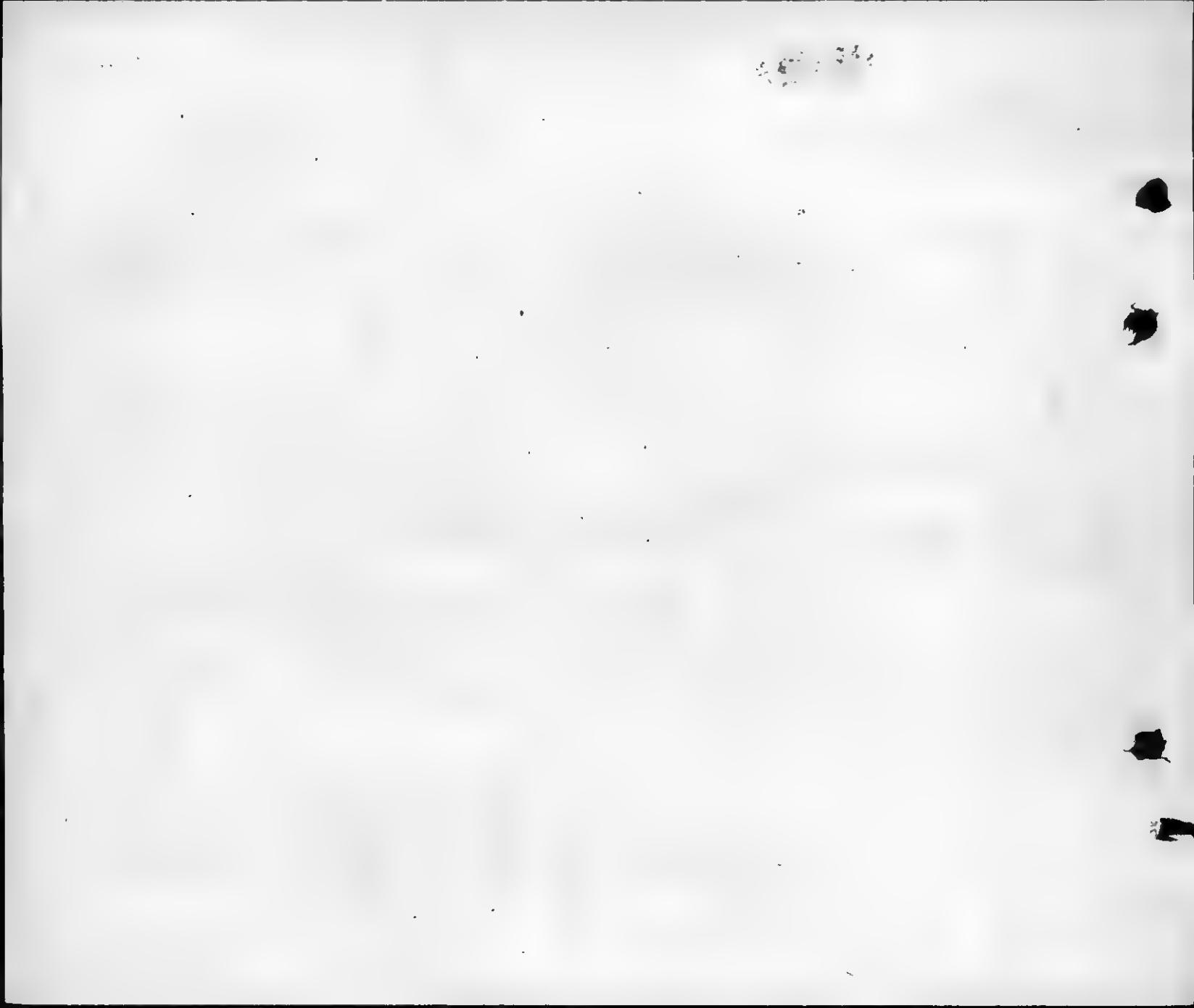
DR. BELL 119

W.H.S.

1

VR A15 (4)

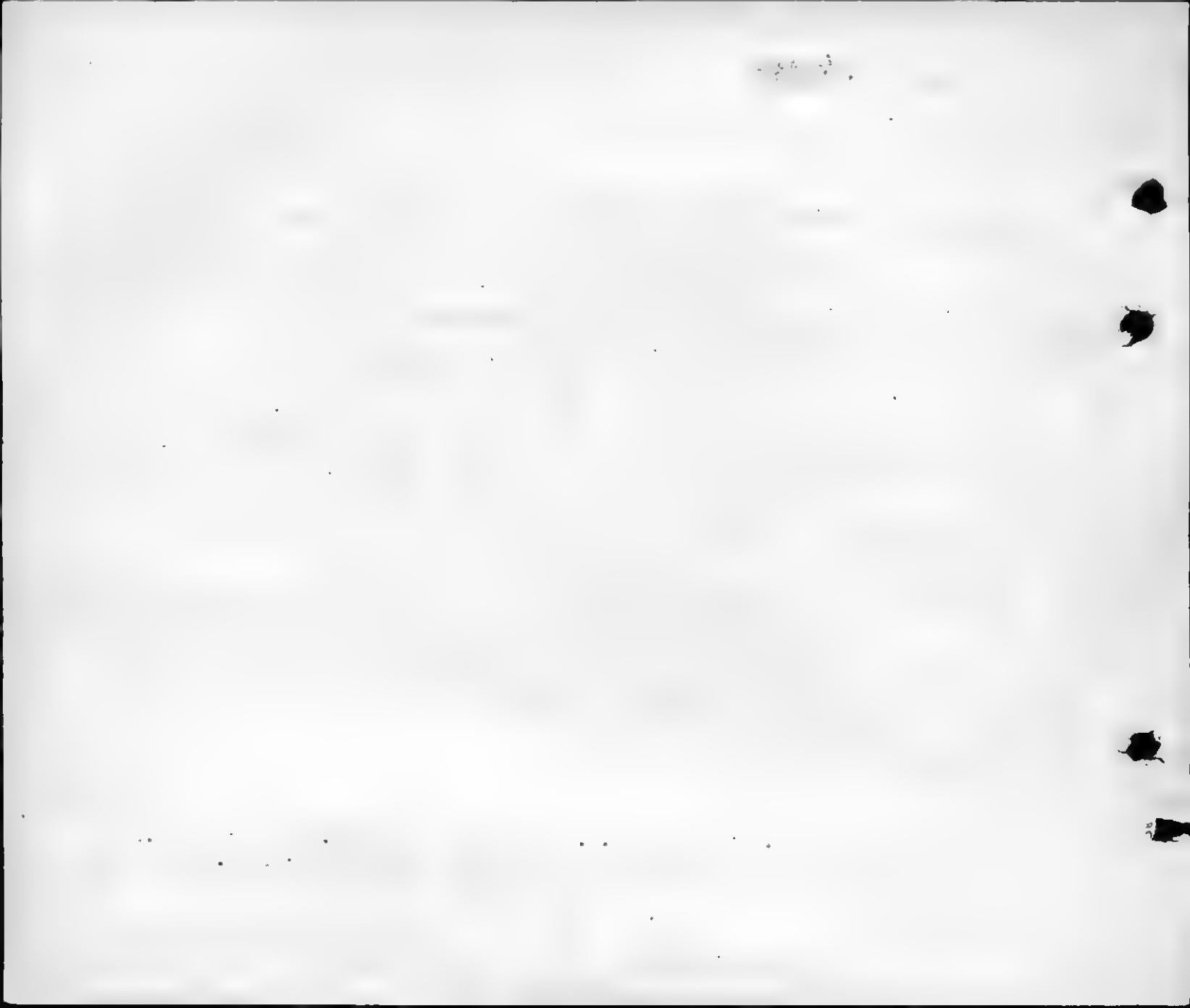
15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

112393

1. PLACE OF DEATH o. COUNTY		2423 Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		c. LENGTH OF STAY IN lb		Tenna			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington Co. Hospital		2 weeks		b. COUNTY Franklin ✓			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years, last birthday)	10. UNDER 1 YEAR	11. IF UNDER 24 HRS.	Months Days Hours Min.
Female		White		October 14, 1891		69 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Housekeeping		Franklin Co. Penn		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John P. Hartman		Abbie Jane Myers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		M. Samuel A. Heisey, Jr. 27 Howard St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Atherosclerotic heart disease DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH 15 days - Mucrata -									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary embolus -									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ AM, from the causes and on the date stated above.		21. I certify that (I) (this hospital) attended the deceased from 21.4.1961 to 21.9.1961, that (I) (we) last saw the deceased alive on 21.9.1961, and that death occurred at 20 AM, from the causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE 2:20:61.		
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 W. Washington St., Hagerstown, Md.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/1961		23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		23d. LOCATION (City, town, or county) Muncyburg Franklin Penn (State)			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Zimmerman, Lancaster, Pa.		ADDRESS		25a. REC'D BY REGISTRAR Arthur E. Tamm		25b. REGISTRAR'S SIGNATURE			
				DATE FEB 23 '61					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

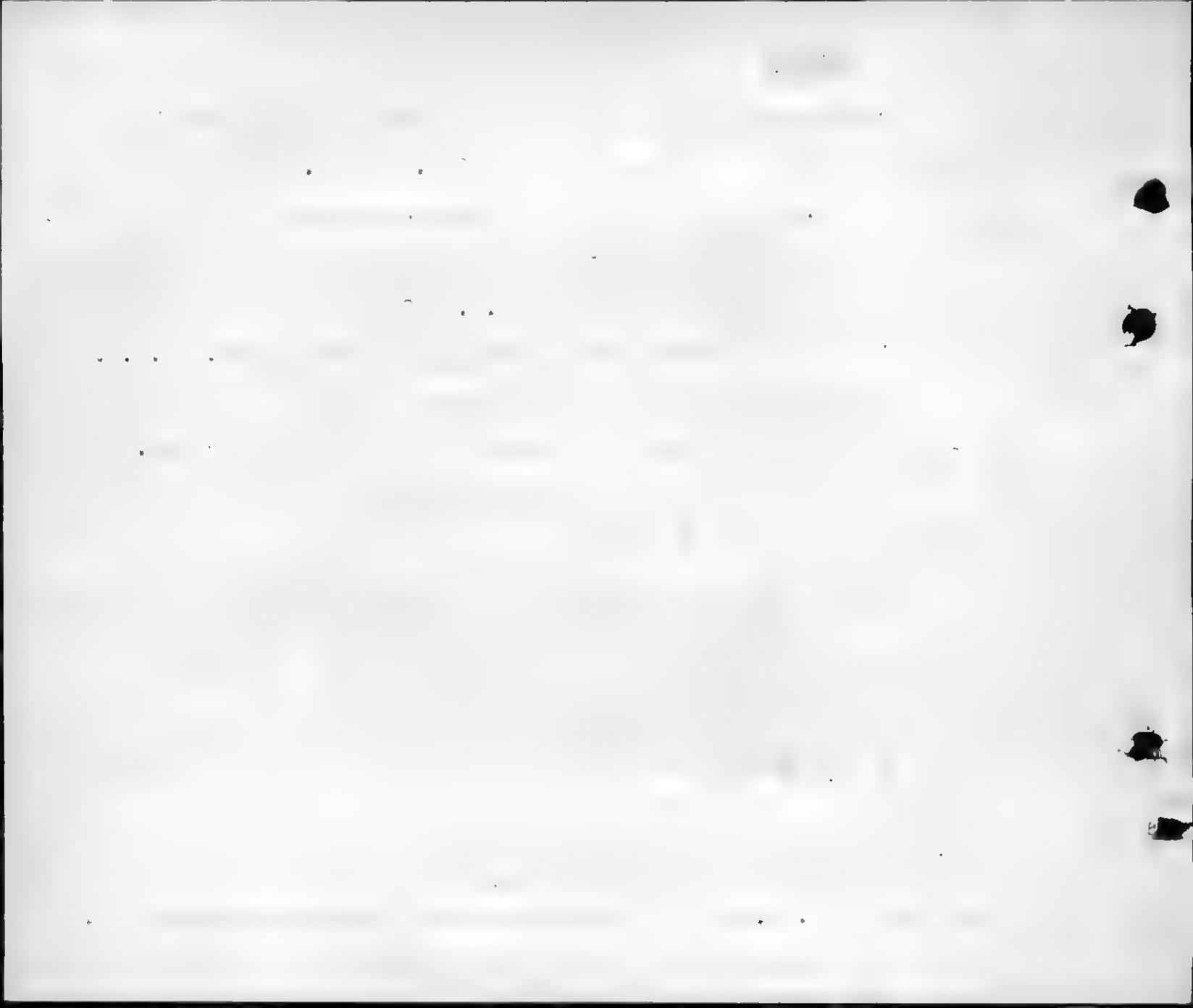
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

024.0

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 E. Main St.	
f. STREET ADDRESS Hancock Maryland		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First McCleve	Middle Henry
4. DATE OF DEATH 2 16 19 61	Month 2	Day 16	Year 19 61
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7. 1882
9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Housewife	12. BIRTHPLACE (State or foreign country) Washington County Md.
13. FATHER'S NAME John W Burgeas	14. MOTHER'S MAIDEN NAME Mary D Bootman	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO None	17. INFORMANT Charles E Henry Jr Hancock Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Myocardial Infarction PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 2 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 25 1961 to Jan 4 1961 , that (I) (we) last saw the deceased alive on Jan 4 1961 , and that death occurred at 5 A M , from the causes and on the date stated above.			
22a. SIGNATURE Frank B Thomas III M.D.	M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 2-18-61	
22c. PHYSICIAN'S NAME (Type) FRANK B THOMAS III M.D.	22d. ADDRESS HANCOCK, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2.18.61	23c. NAME OF CEMETERY OR CINERARY St Thomas Episcopal	23d. LOCATION (City, town, or county) (State) Hancock Washington Md.
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Glone	ADDRESS Hancock Maryland	25a. REC'D BY REGISTRAR FEB 23 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Knapp



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after

death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2425

CERTIFICATE OF DEATH

1024

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Hagerstown

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

R.F.D. # 3

3. NAME OF
DECEASED
(Type or print)

First
CORA

Middle
MAE

HOCKERSMITH

Last

4. DATE
OF
DEATH
February

Day
13
1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED
WIDOWED

Divorced

8. DATE OF BIRTH

December 3, 1887

9. AGE (in years
last birthday)

73 yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIR

12. ACE (County & State, or foreign country)

Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Calvin B. Thurston

14. MOTHER'S MAIDEN NAME

Lucretia Schlaigh

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Mrs. George Bellinger

Hagerstown, Maryland

INTERVAL BETWEEN
ONSET AND DEATH

3 weeks

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

530 X
Conditions, if any, which
gave rise to immediate cause

(a), stealing the underlying
cause lost.

DUE TO

(b)

DUE TO

(c)

Subarachnoid Memorrhage

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

21f. (City or town)
(County)
(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 25, 1961 to Feb. 12, 1961 that (I) (we) last
saw the deceased alive on Feb. 12, 1961, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

R. A. Bell, M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED

Feb. 13, 1961

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Cremation

23b. DATE THEREOF
2/13/1961

23c. NAME OF CEMETERY OR CREMATORIUM
Cedar Hill Cemetery

23d. LOCATION (City, town or county)

(State)

Washington,

D. C.

24. FUNERAL DIRECTOR'S SIGNATURE

Suter - Rouzer Funeral Home

ADDRESS

Hagerstown, Maryland

25a. REC'D BY REGISTRAR

FEB 16 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

scoring

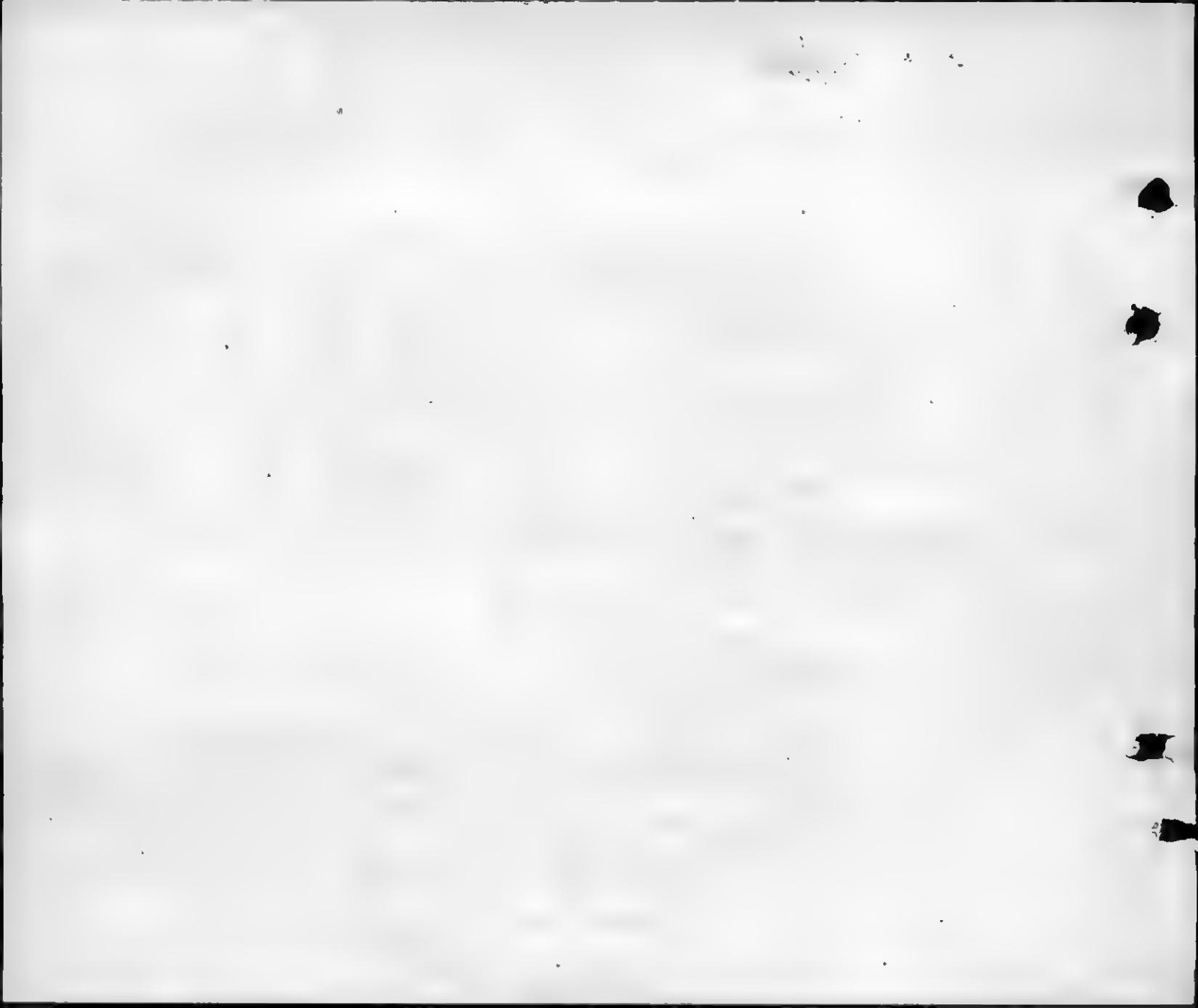
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2426

CERTIFICATE OF DEATH

02412

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Yrs		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Conv. Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First JOHN	Middle ALBERT	Last HOOVER	4. DATE OF DEATH February 23 1961 19	Month February	Day 23	Year 1961		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10 1872	9. AGE (In years last birthday) 88 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME J. Dallas Hoover		14. MOTHER'S MAIDEN NAME Aranda Brill								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs Margaret Neikirk 1344 Salem Ave		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Arterio Sclerotic Cardiachis		Hagerstown Md. Acute Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs.				
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jan 15 1959 to Feb 22 1961		(County)		(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1959</u> to <u>Feb 22 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 20 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.										
22a. SIGNATURE David R. Brewer		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 2/23/61				
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md.		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Klaus				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2427

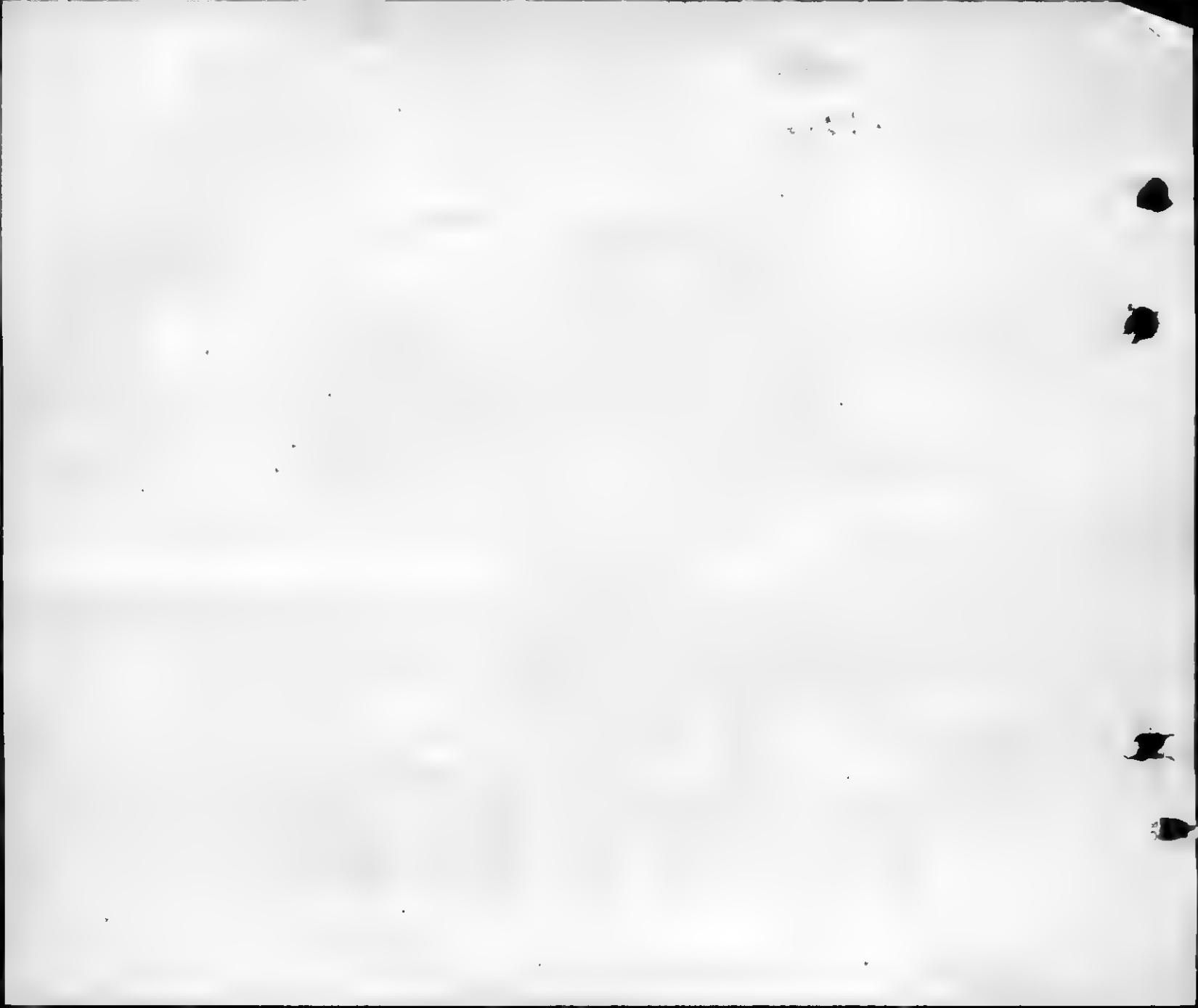
302

02403

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 12 East Washington St		d. STREET ADDRESS 12 East Washington St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) RHODA		First MAY	Middle HUNSBERGER	Last 	4. DATE OF DEATH Feby 10 1961	Month 19	Day 	Year 	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jany 20 1879		9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	IF UNDER 24 HRS Hours 	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William F. Cramer		14. MOTHER'S MAIDEN NAME Rebecca Semler							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Elda Stahl 12 E. Washington St		Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		<i>Obstruction</i>		<i>Hypertension Cardiac Vasculitis</i>		INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) 	(State)
21. I certify that (I) (this hospital) attended the deceased from 1-20-1961 to 2-10-1961 , that (I) (we) last saw the deceased on 2-9-1961 , and that death occurred at 6 AM , from the causes and on the date stated above.									
22a. SIGNATURE <i>John Dally</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 			
22c. PHYSICIAN'S NAME (Type) John Dally		22d. ADDRESS Hagerstown Md.							
23a. BLR A. CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown Wash Co Md.		(State) 	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS 		25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Francis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



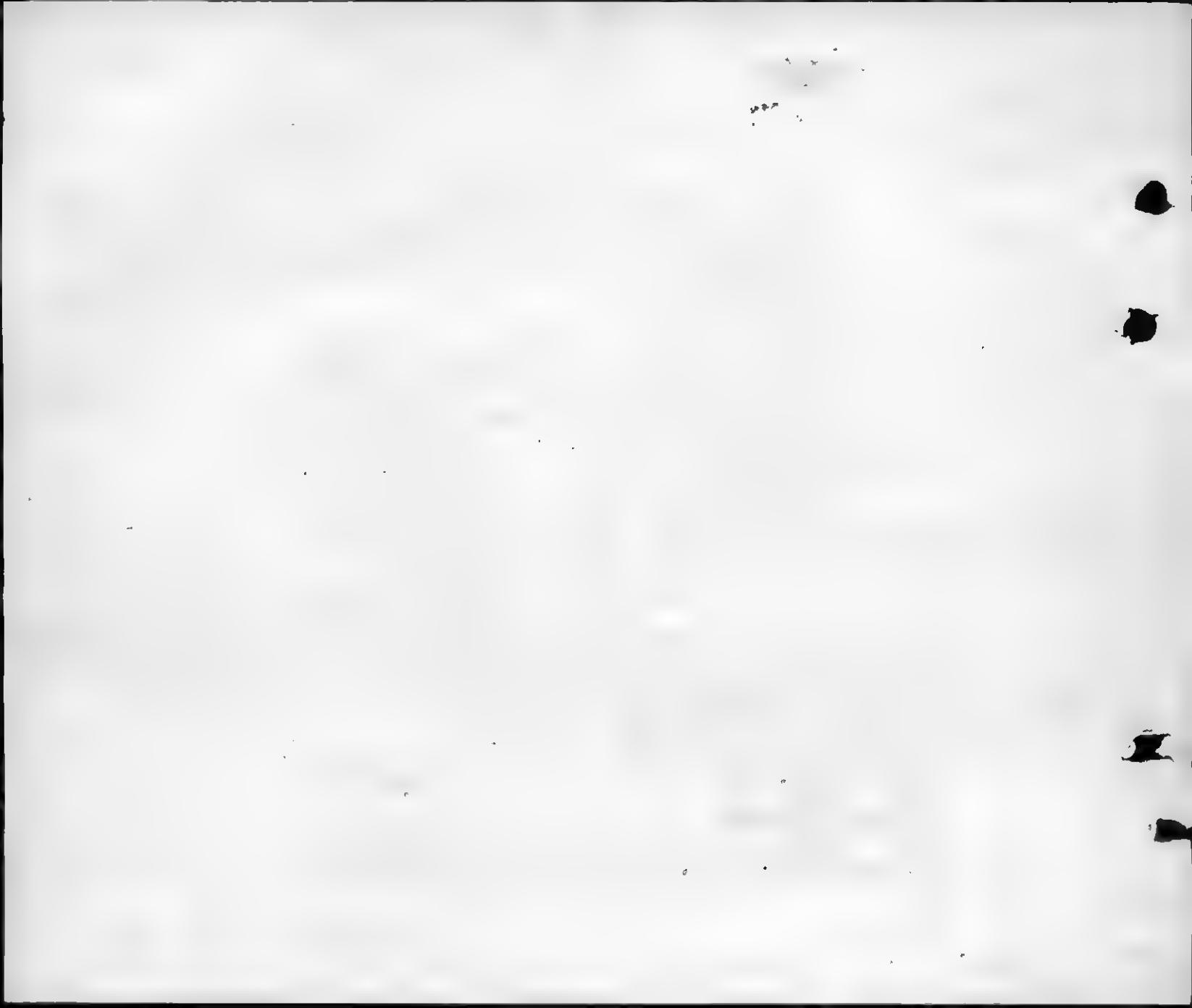
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

024-14

1. PLACE OF DEATH a. COUNTY		2428 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		3. LAND Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 18 mos		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 377 Penna Ave				d. STREET ADDRESS 377 Penna Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First GLADYS	Middle MAY	Last JAMES	4. DATE OF DEATH	Month February	Day 20	Year 1961	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 6 1904	9. AGE (In years lost birthday) 36 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Somerset Somerset Co		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ezron Evans		14. MOTHER'S MAIDEN NAME Elizabeth							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 438-32-7654		17. INFORMANT Fred J. James Jr 377 Penna Ave		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 2 hours.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Arteriosclerotic heart disease				1 year			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1951 19 to 2/20/61 19, that (I) (we) last saw the deceased alive on 1.20.61 19, and that death occurred at 9:00 A.M. from the causes and on the date stated above									
22a. SIGNATURE S. Earl Young M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS 148 N. Potomac St., Hagerstown, Md.		22b. DATE SIGNED 1/20/61			
22c. PHYSICIAN'S NAME (Type) S. Earl Young M.D.									
23a. BURIAL, Cremation, or Removal (Specify) Burial		23b. DATE THEREOF 3/2/61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coflin Hagerstown Wash Co. Inc.		ADDRESS		25a. REC'D BY REGISTRAR FEB 23 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

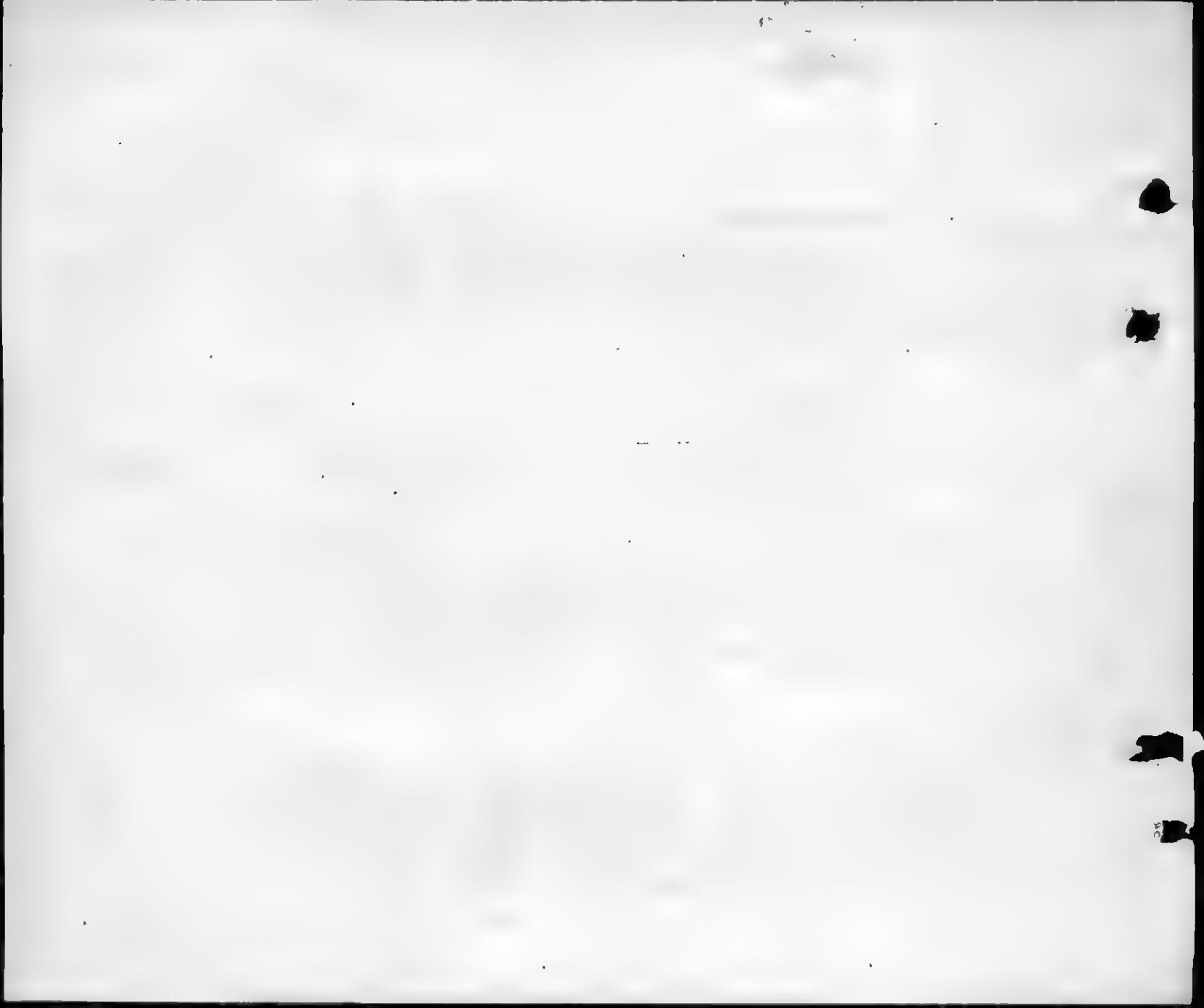
2429

CERTIFICATE OF DEATH

302

02495

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wash ton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 38 No Mulberry St			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				d. STREET ADDRESS 38 No Mulberry St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY BENDER		First	Middle	Last	4. DATE OF DEATH Feb 9 1961	Month	Day	Year 19	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 31 1883	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Sharpsburg Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Jacob Bender				14. MOTHER'S MAIDEN NAME Barbara A. Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 314-09-6193		17. INFORMANT Miss Elizabeth King 28 No Mulberry St.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 334 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cerebral Atherosclerosis (c) DUE TO Cerebral Atherosclerosis				Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 67 1/2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Underlying cause of death						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury							
20c. TIME OF INJURY Hour a.m. p.m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Feb 1961, and that death occurred at 7 AM, from the causes and on the date stated above						19 25 1a 8 AM, 1961			
22a. SIGNATURE Johnson		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/61		23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2430

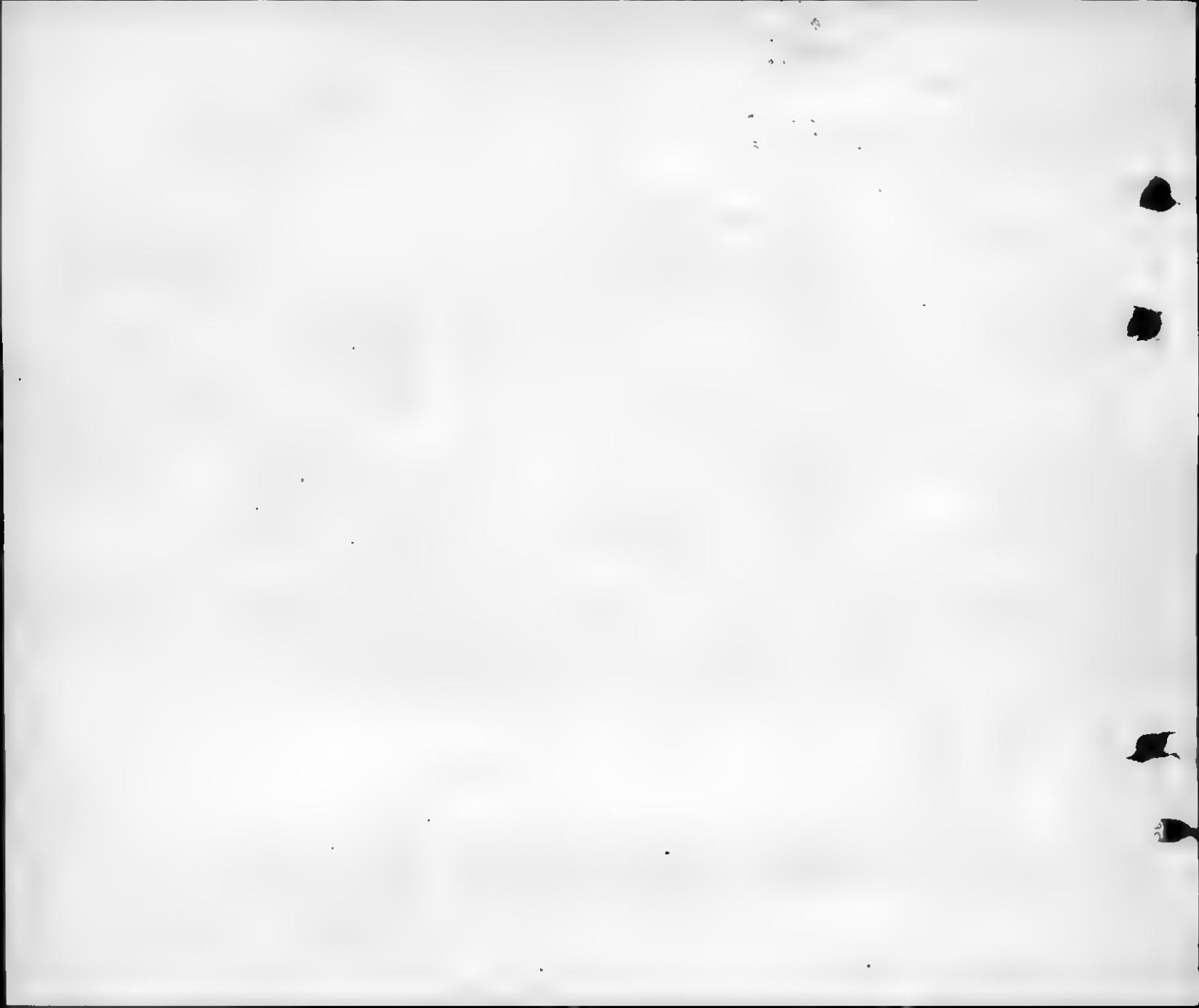
CERTIFICATE OF DEATH

102466

TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 49 East Washington St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home				d. STREET ADDRESS 49 East Washington St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BEDA	Middle S	LaMAR	4. DATE OF DEATH February 20 1961	Month 19	Day 19	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feby 14 1876	9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co		12. CITIZEN OF WHAT COUNTRY? Lapahs Cross Road USA	
13. FATHER'S NAME Marene LaMar				14. MOTHER'S MAIDEN NAME Annie Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs Viola Wayland 3500 Saul Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). 145 <i>Breathlessness</i> Kensington Md. INTERVAL BETWEEN DUE TO <i>hypertension</i> onset and death Conditions, if any, which <i>cardiac</i> <i>failure</i> <i>hypertension</i> <i>3 yrs</i> gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>cardiac</i> <i>failure</i> <i>hypertension</i> <i>1 yr</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPISY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-1-1961 to 2-20-1961, that (I) (we) last saw the deceased alive on 2-2-1961, and that death occurred at 12 P.M. from the causes and on the date stated above							
22a. SIGNATURE <i>R. E. Coffman</i>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R. E. Coffman</i>		22d. ADDRESS <i>Hagerstown Md</i>		22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/03/61		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
						25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exhibited to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

024-17

1. PLACE OF DEATH a. COUNTY <i>Washington Co.</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Penna.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		c. LENGTH OF STAY IN 1b <i>5 yrs. & 4 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Williamsport Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Dr. Horace Werten Lightner</i>		First <i>Horace</i>	Middle <i>Werten</i>
4. DATE OF DEATH <i>February 11 1961</i>		Last <i>Lightner</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct. 28, 1869</i>		9. AGE (In years lost birthday) 91 yrs. 3 months 13 days 13 hours 0 min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dentist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dentist</i>	
11. BIRTHPLACE (State or foreign country) <i>Landisburg, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Lightner</i>		14. MOTHER'S MAIDEN NAME <i>Martha (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Bruce Lightner, Williamsport, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>492X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Atherosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1 1958</i> to <i>Feb. 14, 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb. 10, 1961</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>2-22-61</i>	
22c. SIGNATURE <i>M.E. Byrkit</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. ADDRESS <i>Williamsport Md.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 14-61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cemetery</i>		23d. LOCATION (City, town, or county) <i>Hagerstown Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Byrkit Williamsport, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 15 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 1 may be retained by the hospital or attending physician.

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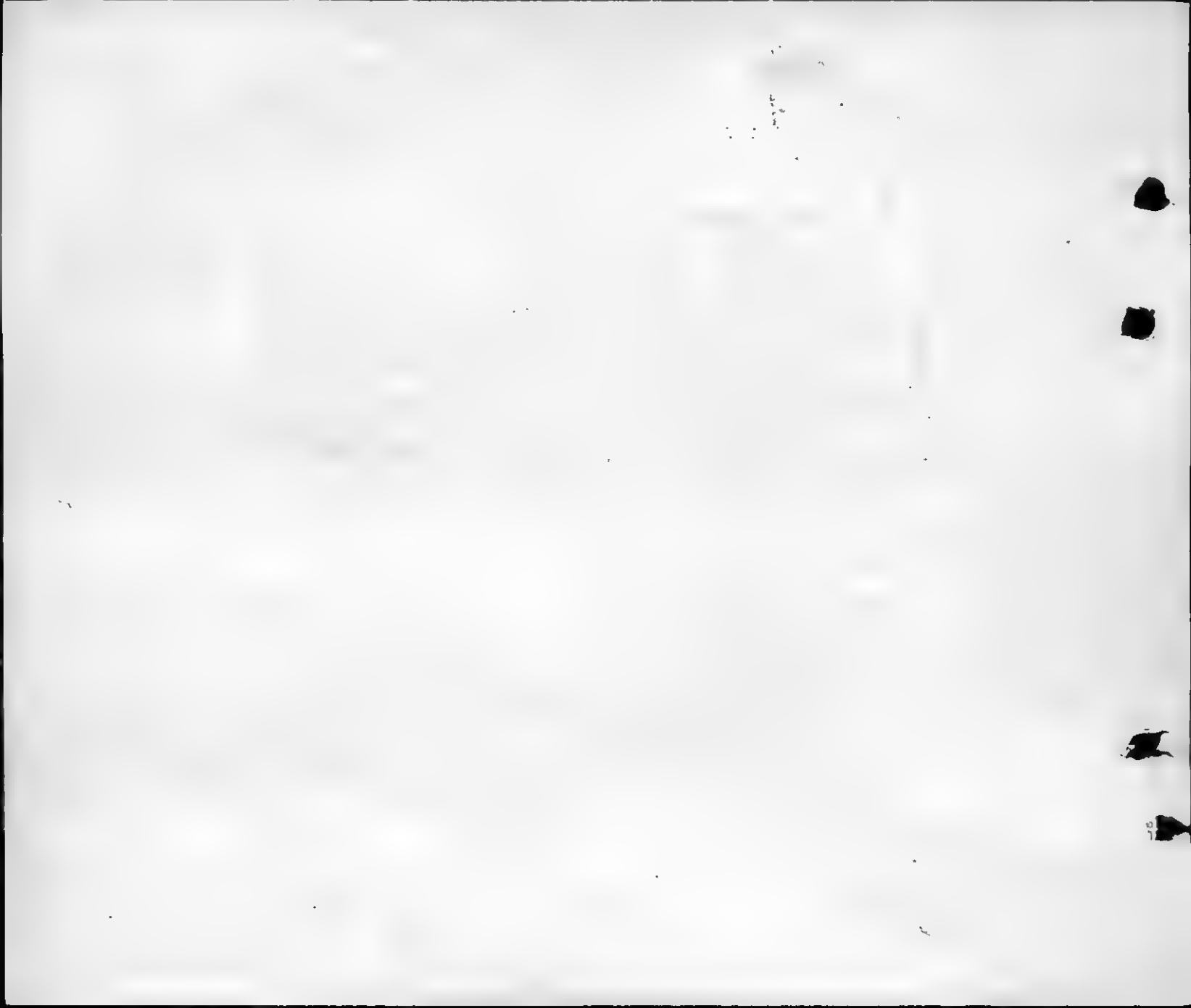
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

024-8

2432

1. PLACE OF DEATH a. COUNTY <i>wash.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		b. COUNTY <i>wash.</i>	
c. LENGTH OF STAY IN 1b <i>1 Day.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR [INSTITUTION] <i>Wash. Co. Hospital</i>		d. STREET ADDRESS <i>12045 Penna. Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Adin</i>	Middle <i>H.</i>	Last <i>MARTIN</i>
4. DATE OF DEATH	Month <i>Feb.</i>	Day <i>9</i>	Year <i>1961</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/8/1899</i>
9. AGE (In years last birthday) <i>61 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	12. BIRTHPLACE (State or foreign country) <i>Wash. Co., Md.</i>
13. FATHER'S NAME <i>Amos M. Martin</i>	14. MOTHER'S MAIDEN NAME <i>Amanda L. Horst</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>815-36-796</i>	17. INFORMANT <i>Mrs. Elizabeth Martin</i>	Address <i>2045 Pa. Ave Hagerstown, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Curvular Hernia</i>			
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>			
b) <i>Curvular Hernia</i>			
DUE TO <i>Causes of death unknown</i>			
c) <i>Unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>53</i> (County) <i>87-61</i> (State) <i>1961</i>
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>8 Feb 1961</i> , and that death occurred on <i>11 Feb 1961</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>3/10/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>John J. Martin</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <i>B</i>		23b. DATE THEREOF <i>2/12/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Reiff Cem.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. E. Minnick - Green Castle Pt.</i>		ADDRESS <i>1500 Green Castle Rd.</i>	25a. REC'D BY REGISTRAR DATE <i>FEB 14 1961</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~mailed~~ within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

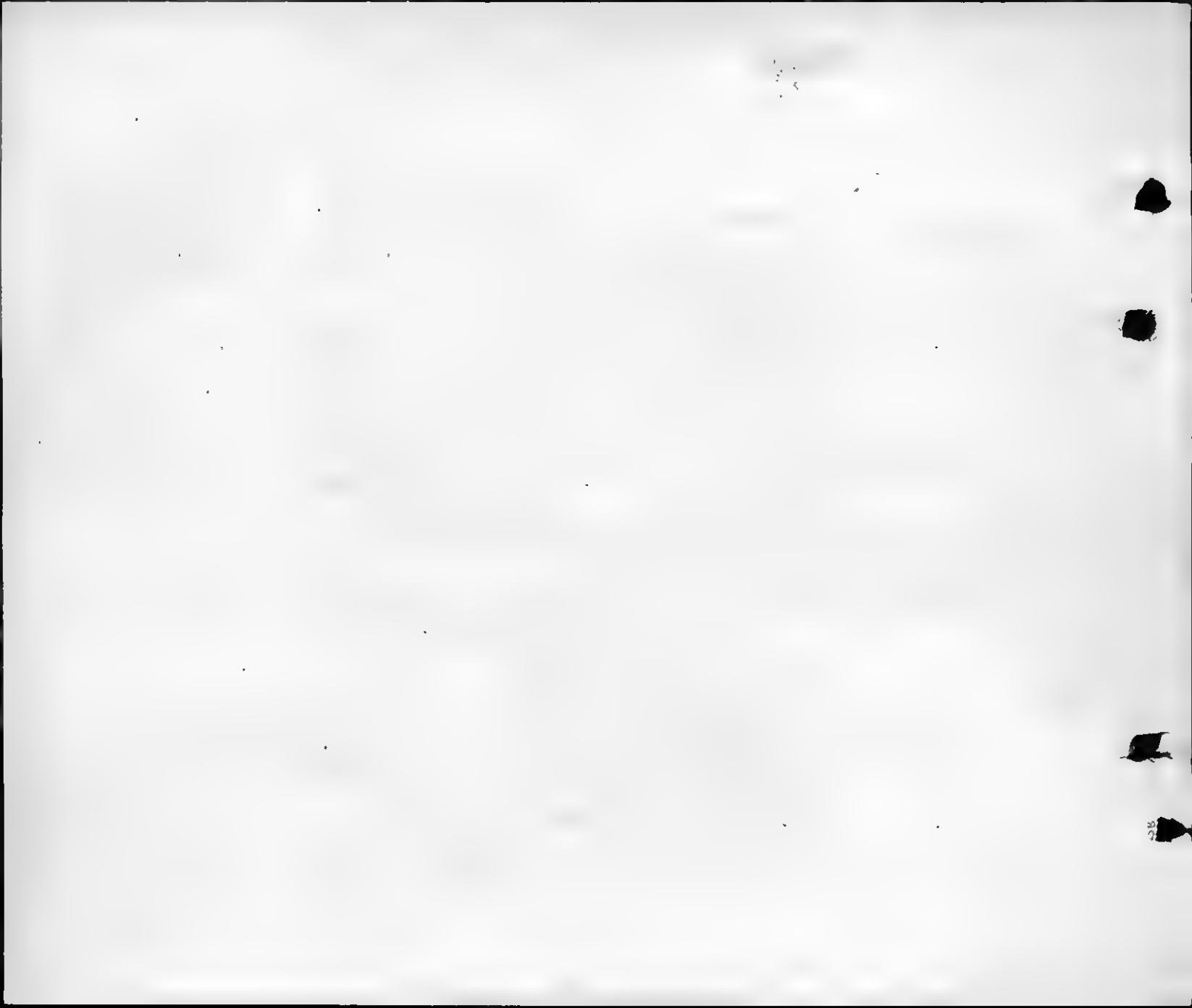
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2433 (02433)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md., b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 55 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS 129 John St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) David Roszel McConnell, Sr.			4. DATE OF DEATH Feb. 6, 1961	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1877		9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK			10b. KIND OF BUSINESS OR INDUSTRY wholesale notions		11. BIRTHPLACE (State or foreign country) Mercersburg, Pa.	
13. FATHER'S NAME David McConnell			14. MOTHER'S MAIDEN NAME Margaret S. Ender			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] no			16. SOCIAL SECURITY NO. 214-09-7443		17. INFORMANT Clarence H. McConnell, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic heart disease (c)			19. INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonitis, right lower lobe, cerebral arteriosclerosis			20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour — a. m. —————— 19 p. m. —————— at work <input type="checkbox"/> at work <input type="checkbox"/>			20d. INJURY OCCURRED at home <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-21-55 to February 6, 1961, that (I) (we) last saw the deceased alive on February 6, 1961, and that death occurred at 2:31 PM, from the causes and on the date stated above			22b. DATE February 7, 1961			
22a. SIGNATURE Robert F. Keadle			22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DIED February 7, 1961			
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle			22d. ADDRESS 318 North Potomac Street, Hagerstown, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-61	23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		23d. LOCATION (City, town, or county) Mercersburg, Penna. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.			25a. REC'D BY REGISTRAR FEB 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kinnar	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2434

CERTIFICATE OF DEATH

02411

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 Days						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Edward Robert McCullough		First	Middle					
4. DATE OF DEATH 2 11 19 61		Last	Month	Day	Year			
S. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 6.9.1889	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wild Life Field Sup.		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Morgan County W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Dr. William H McCullough		14. MOTHER'S MAIDEN NAME Catherine Rockwell		Address Md.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-0878		17. INFORMANT Mrs Ruth McCullough Rural 1 Hancock		INTERVAL BETWEEN ONSET AND DEATH less than 24 hrs.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolus 46 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis, right temporal region with left sided hemiplegia; diabetes mellitus; arteriolar nephrosclerosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) Howard J. Stone attended the deceased from Feb. 5 1961 to Feb. 11 1961 , that (I) (w) last saw the deceased alive on Feb. 11 1961 , and that death occurred at M. from the causes and on the date stated above.		22a. SIGNATURE W. T. Layman, M.D.						
22b. DATE SIGNED		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland						
23a. BURIAL, CREMATION REMOVAL (Specify) Buried		23b. DATE THEREOF 2.14.61		23c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		23d. LOCATION (City, town, or county) Hancock Washington Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone Hancock Md.		25a. REC'D BY REGISTRAR DATE FEB 17 '61						
		25b. REGISTRAR'S SIGNATURE Arthur S. Evans						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2430

CERTIFICATE OF DEATH

112411

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~mailed~~ within 24 hours of or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Wash.	MARYLAND	2. USUAL RESIDENCE (Where deceased lived)		If institution, Residence before admission	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE	Pa.	b. COUNTY	Franklin ✓
Hagerstown		13 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural - Anttrim Twp. 75X-2	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION		Wash. Co. Hospital		4. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day Year
IDA		E.	MOWEN		Feb.	27	1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS
F	W	WIDOWED <input checked="" type="checkbox"/>	12/29/1877	83 yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housekeeper		Home		Scotland, Pa.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
George Peiffer		Fianna Wingert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
None		None		Ralph Mowen		R03 Greencastle, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage				23 days	
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 4 1961 to Feb. 27 1961, that (I) (we) last saw the deceased alive on 27 1961, and that death occurred at 1:50 P.M. from the causes and on the date stated above							
22a. SIGNATURE G.W. Elsler		22b. DATE SIGNED 2/28/61					
22c. PHYSICIAN'S NAME (Type) Paul F. Webster, M.D.		22d. ADDRESS 27 S. Carlisle St., Greencastle, Penna.					
23a. BURIAL, CREMATION, REMOVAL (Specify) B.		23b. DATE THEREOF 3/2/61		23c. NAME OF CEMETERY OR CREMATORIAL Grundstone Hill, Cen.		23d. LOCATION (City, town, or county) (State) near Chambersburg, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE A.E. Mennich - Greencastle, Pa.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

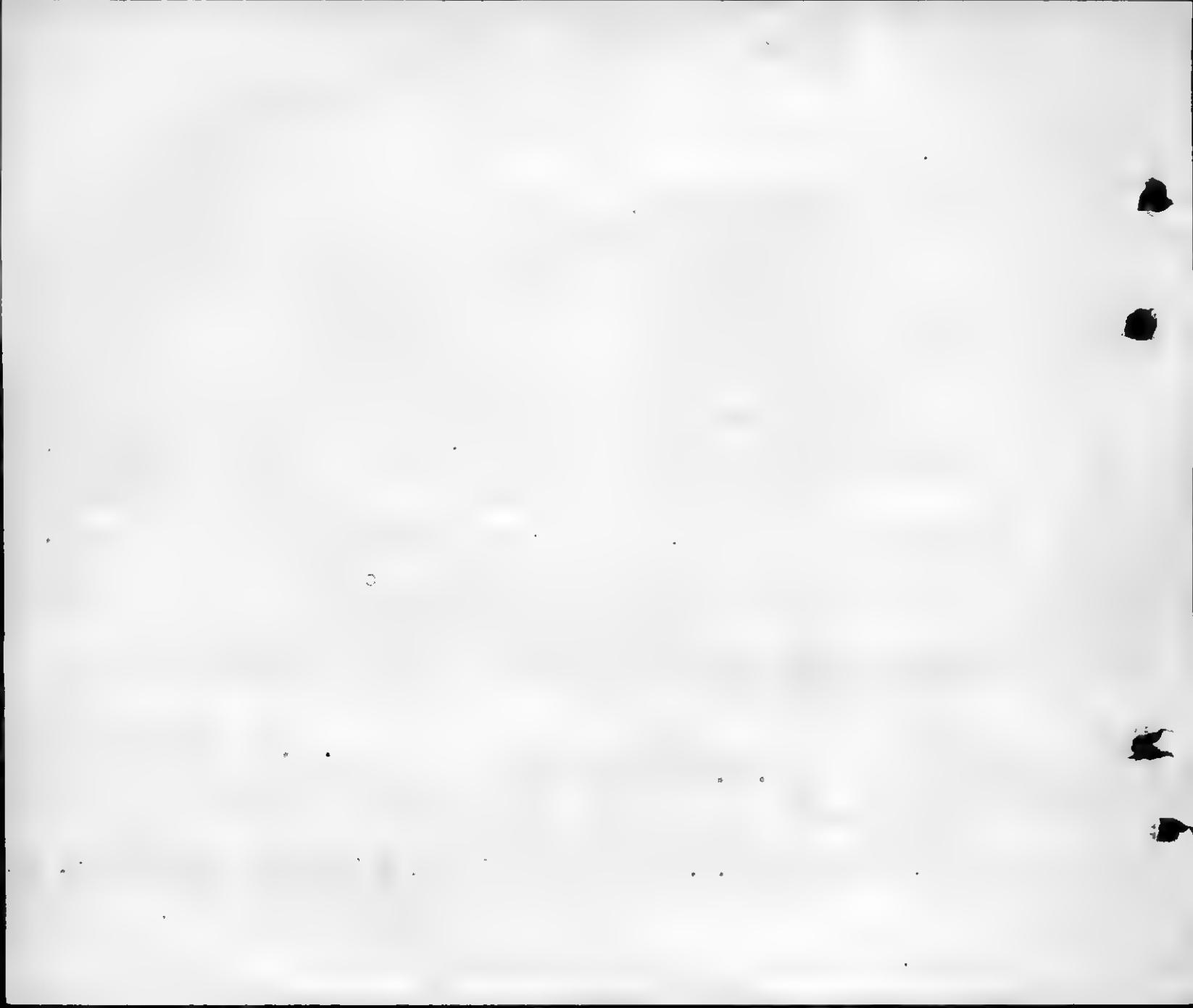
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02412

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Hagerstown		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 West Washington St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) Terrie Viola Mullenix		d. STREET ADDRESS 11 West Washington St.	
4. DATE OF DEATH February 12 1961		Month	Day
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1891
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 70 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Near Greencastle, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jousha Lale		14. MOTHER'S MAIDEN NAME Lottie Staudau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jan A. Mullenix		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 420-0 Conditions if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) Arteriosclerotic Heart Disease. DUE TO (c) Adenomarcinoma transverse colon		8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		5 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown (County) Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from 1942 to 1961 , that (I) (we) last saw the deceased alive on 2.10.61 , and that death occurred on 5.25.61 , from the causes and on the date stated above.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) S. Earl Young M.D.		M.D. <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 148 N. Potomac St., Hagerstown, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-15-61	
23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott Finnich & Son		ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR FEB 15 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Evans



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2437

112413

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 16

MARYLAND

1 week

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF

First

Middle

Last

(Type or print)

Russell

Murray

4. DATE
OF
DEATH

Feb.

Month

7

Day

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

April 26 1886

9. AGE (in years
last birthday)

74
yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. BIRTHPLACE (County & State, or foreign country)

Ret'd Track Foreman

Western Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Stephen Franklin

14. MOTHER'S MAIDEN NAME

Susan Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or details of service)

No

16. SOCIAL SECURITY NO.

705 10 5914

17. INFORMANT

Susan Murray 20 W. Salisbury St.
Williamsport Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

Pontonitis

Cholecystectomy

INTERVAL BETWEEN
ONSET AND DEATH

3 days

5 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

19. WAS AUTOPSY
PERFORMED? YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1 Feb. 1961, to 7 Feb. 1961, that (I) (we) last
saw the deceased alive on 7 Feb. 1961, and that death occurred at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE

E. Edmon D. Hoachlander
22c. PHYSICIAN'S
NAME (Type)

ATTENDING MED. STAFF
PHYS. DIRECTOR PHYS.

22b. DATE
SIGNED
2/1/61

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE THEREOF
Feb. 11-61

23c. NAME OF CEMETERY OR CREMATORIUM

Parkhead E.U. B Cemetery

23d. LOCATION (City, town or county) (State)
Church Cemetery Near Hancock Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Albert & Leopold Williamsport, Md.

ADDRESS

25e. REC'D BY REGISTRAR
DATE FEB 14 '61

25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas

VR A15 (4)
15M 9/60



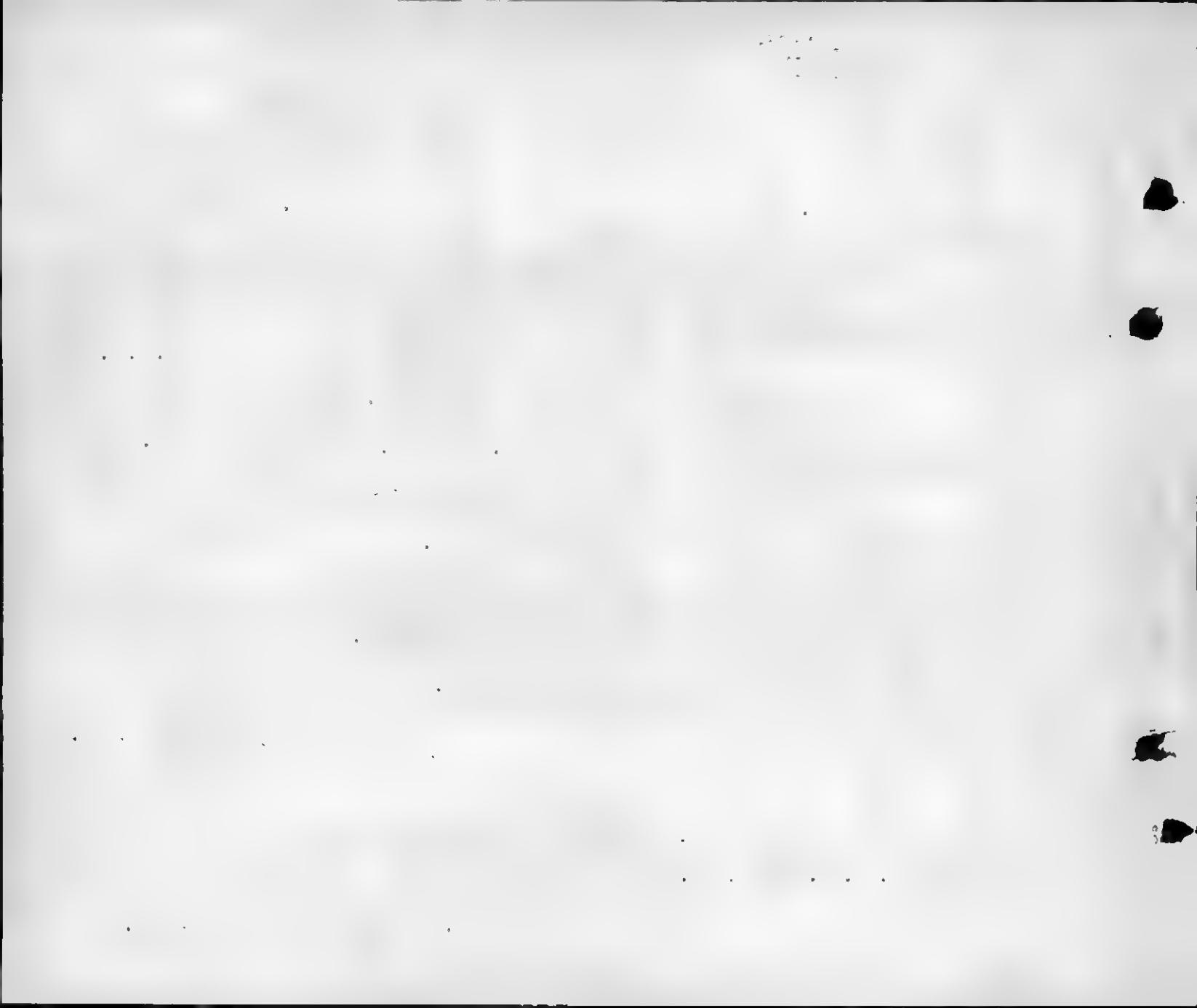
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02414**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY 2418 WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MITCHELL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANKLIN	First FRANKLIN	Middle RUSSELL	Last MYERS
4. DATE OF DEATH 1/18/61	Month JAN	Day 12	Year 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/18
			9. AGE (In years last birthday) 57 yrs.
			10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
			Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST HELPER		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	
11. BIRTHPLACE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SOLOMON MYERS		14. MOTHER'S MAIDEN NAME ALICE VA. HICKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-4654 MRS. EDNA M. MYERS	
17. INFORMANT HAGERSTOWN MD.		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self inflicted Gunshot wound of Head with DUE TO Instant			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Active Lacerations Of Brain.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Patient had been rather despondent for some time past.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound.	
20c. TIME OF INJURY Month, Day, Year Hour 2-12 p. m. 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 1961	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown, Md.		20f. (City or town) Hagerstown, Md. (County) Washington Co. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. V. Ditto Jr.		DATE SIGNED 2-17-61	
EXAMINER'S NAME (Type) Dr. E. V. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/17/61	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SALEM CHURCH CEM.		22d. LOCATION (City, town, or county) WASHINGTON CO. MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE 24a. REC'D BY REGISTRAR FEB 20 '61	
		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

112415

2439

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA				b. COUNTY FRANKLIN		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAN MAR		c. LENGTH OF STAY IN lb SINCE 6-1-57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DILLON'S MILL VA.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAHRNEY KEEDY MEMORIAL HOME				d. STREET ADDRESS DILLON'S MILL VA.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) BENJAMIN THOMAS NAEFF		First	Middle	Last	4. DATE OF DEATH FEBRUARY - 15. 1961	Month	Day	Year		
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23 - 1868		9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months 8 Days 22 Hours 0 Min.		11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINISTER		10b. KIND OF BUSINESS OR INDUSTRY BRETHELIAN CHURCH		11. BIRTHPLACE (State or foreign country) FRANKLIN CO. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOEL NAEFF		14. MOTHER'S MAIDEN NAME MARY EMILY BOONE				Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RECORDS OF FAHRNEY-KEEDY MEMORIAL HOME		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) (c) DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				INTERVAL BETWEEN ONSET AND DEATH 74+
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>31 nevskiy arteria selozit's Ranegi nevskiy art to q 3 daliatich klyuchev pravosrocc</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) FEB 15 1961		(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 15 1961 to Feb 15 1961 , that (I) (we) last saw the deceased alive on Feb 15 1961 , and that death occurred at 3PM , from the causes and on the date stated above						22b. DATE SIGNED 3/15/61				
22c. PHYSICIAN'S NAME (Type) C. Wilhelm		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF Feb 15 1961		23c. NAME OF CEMETERY OR CREMATORIAL MONTA VISTA CEMETERY		23d. LOCATION (City, town, or county) FRANKLIN CO. VA.		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE John E. Burt		ADDRESS Boonsboro MD		25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

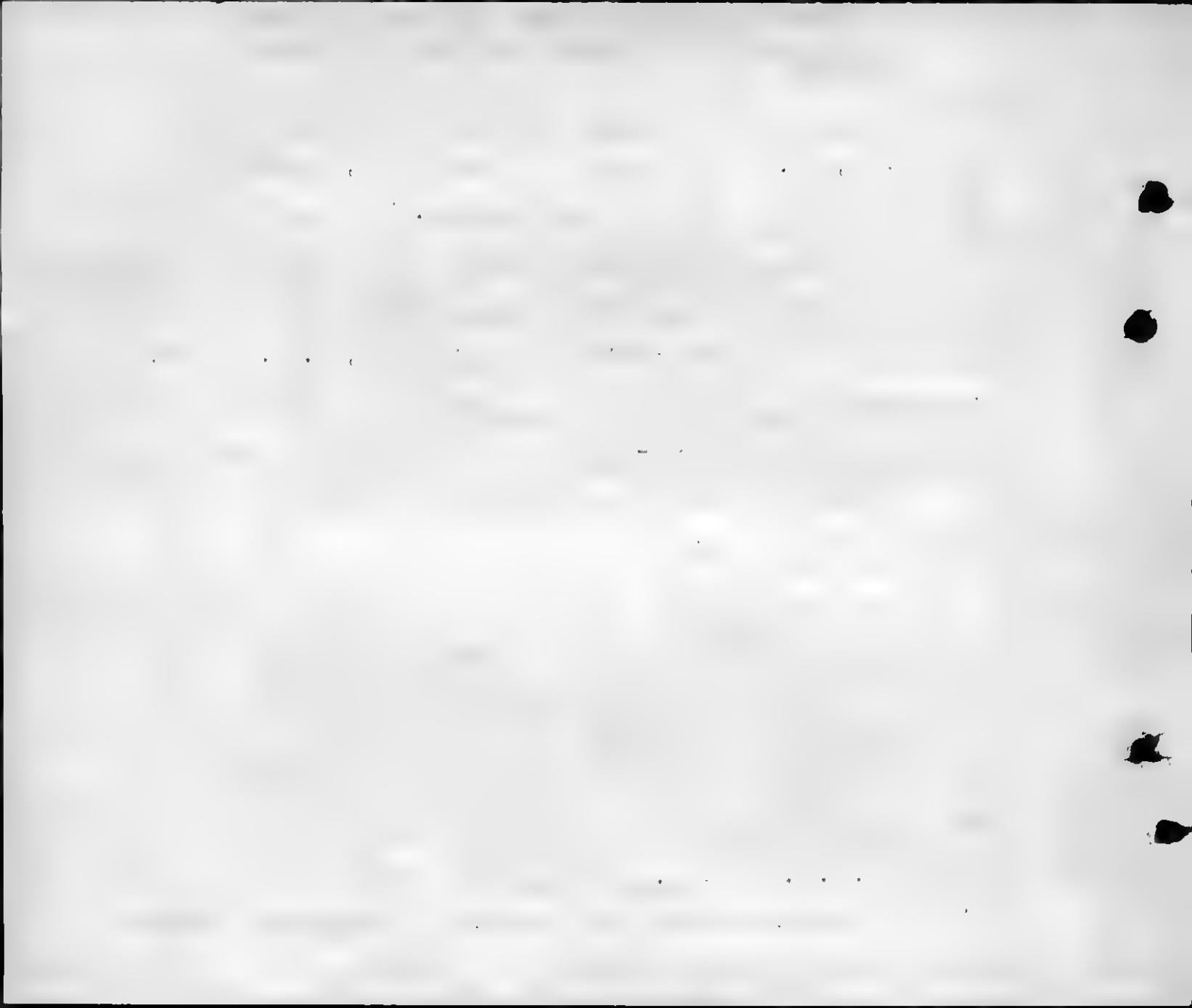
2440 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02416

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 35 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 436 N. Jonathan Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Public Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donald Howard Newman		First Donald	Middle Howard
4. DATE OF DEATH Month Feb		Month 22	Day 19
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 13 1905		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Auto-garage	11. BIRTHPLACE (State or foreign country) Charlestown, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Newman	
14. MOTHER'S MAIDEN NAME Mollie Newman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 216-14-6299		17. INFORMANT Mrs. Etta Newman 436 N. Jonathan St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm Of Aorta		INTERVAL BETWEEN ONSET AND DEATH Recent	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. b) Hemopericardium		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>A. E. J. Ditto Jr.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 2-21-61	
EXAMINER'S NAME (Type) Dr. E. J. Ditto Jr.		22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	
22b. DATE THEREOF Feb 26 1961		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.		24a. REC'D BY REGISTRAR John S. Kraus	
ADDRESS		24b. REGISTRAR'S SIGNATURE John S. Kraus	
DATE MAR 1 '61			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, on most of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



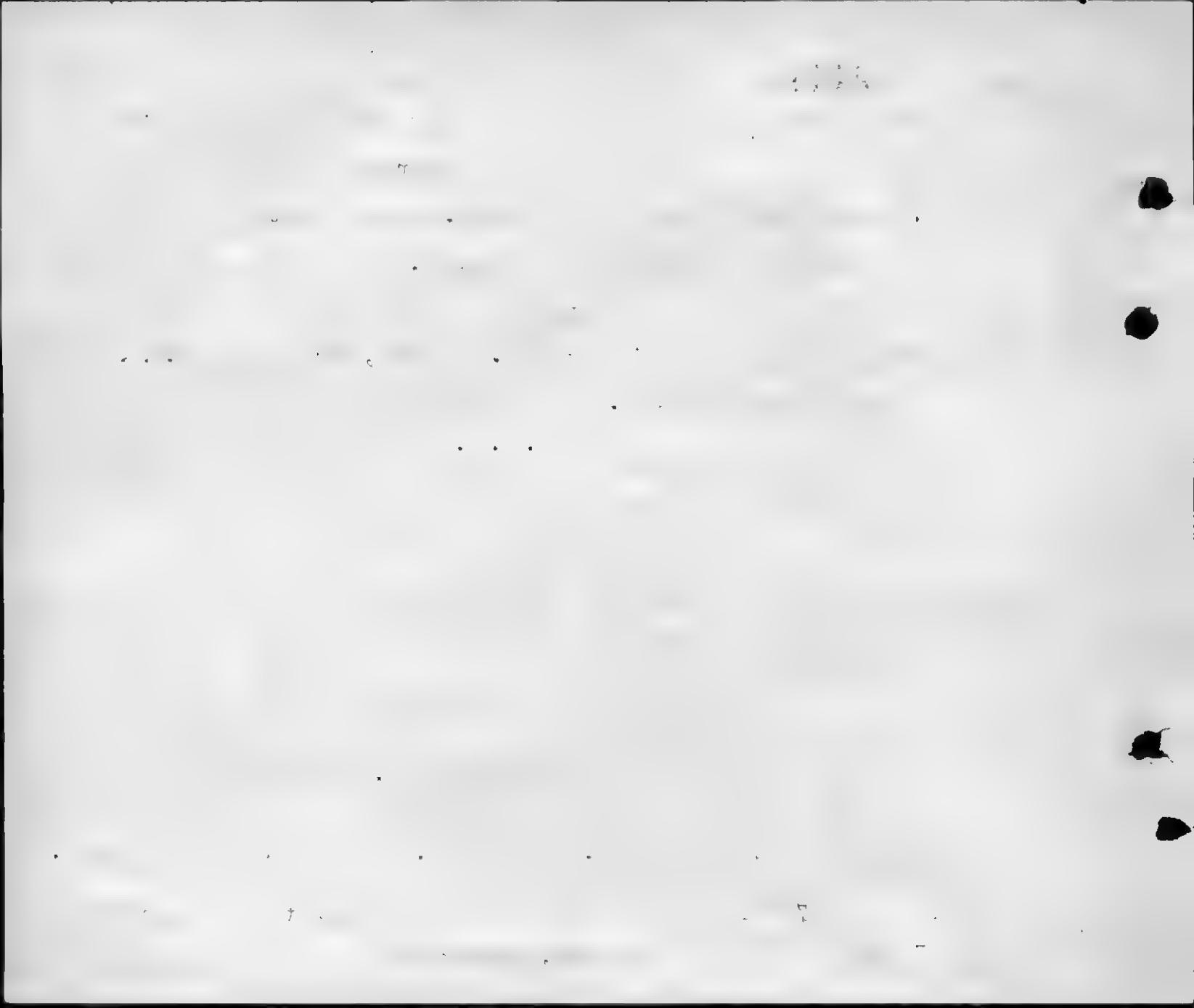
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2441 Items 8 & 9 Film 0282 3/7/61		2441	
1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Washington		e. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY Washington	
Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Hagerstown	
474 N. Potomac Street		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle		Last Month Day Year	
JAMES KINGSLEY		NOEL, JR. February 25 1961	
5. SEX		6. COLOR OR RACE	
Male White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Jan. 24, 1912	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Salesman		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Kingsley Noel, Sr.		Lola Perkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.		17. INFORMANT	
[Yes, no, or unknown] (If yes give rank, dates of service)		Dr. W. W. Noel	
NO		Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		INTERVAL BETWEEN ONSET AND DEATH immediate	
465x		pulmonary embolus	
Conditions, if any, which give rise to immediate cause (e), stating the underlying cause first. (b)		DUE TO	
{		DUE TO	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED?	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/25/61, 19....., to....., 19....., that (I) (we) last saw the deceased alive on 19....., and that death occurred at 9 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 2/27/61	
22c. SIGNATURE Howard N. Wolfe, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Howard N. Wolfe, M.D.		22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/1961	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home J. Franklin Rouzer		25a. REC'D BY REGISTRAR MAR 1 '61	
		25b. REGISTRAR'S SIGNATURE Cathleen S. Harmer	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the physician or attending physician.

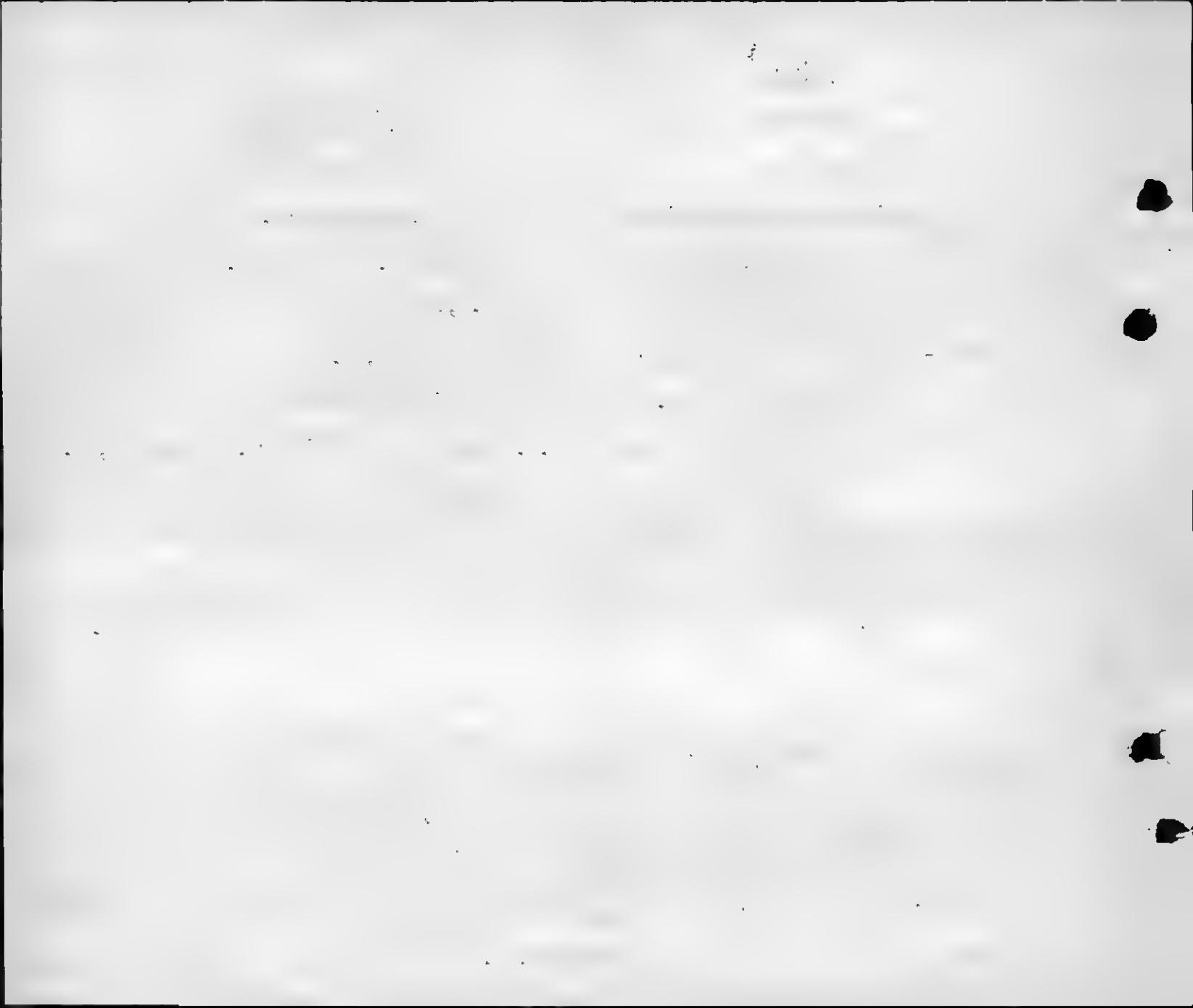
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06418

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 333 Summit Ave.	
e. NAME OF DECEASED (Type or print) Norman Lee		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. SEX Male		f. DATE OF DEATH Pearman Jr. Feb. 4 1961	
g. COLOR OR RACE White		g. DATE OF BIRTH Feb. 1, 1961	
h. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		h. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Norman Lee Pearman Sr.		14. MOTHER'S MAIDEN NAME Connie Mae Snyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES, no, or unknown No		16. SOCIAL SECURITY NO. None	
17. INFORMANT None		18. CAUSE OF DEATH (Enter on one cause per line for (e), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 754.7 DUE TO Conditions, if any, which give rise to immediate cause (e), stating the underlying cause last. (b) (c) DUE TO Dextrocardia	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH At birth	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 2/1/61 p.m. 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 333 Summit Ave. Hagerstown, Md.		20f. (City or town) (County) (State) 333 Summit Ave. Hagerstown, Md.	
21. I certify that (I) (this hospital) attended the deceased from 2/4/61 to 2/4/61 , that (I) (we) last saw the deceased alive on 2/4/61 , and that death occurred at 2 PM , from the causes and on the date stated above.		22. SIGNATURE Richard A. Young	
22c. PHYSICIAN'S NAME (Type) Richard A. Young		22d. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1010ers Farm, Maryland	
23e. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 2/7/61		23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		23d. LOCATION (City, town or county) (State) Williamsport Maryland	
25e. REC'D BY REGISTRAR DATE FEB 7 '61		25b. REG STRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2443

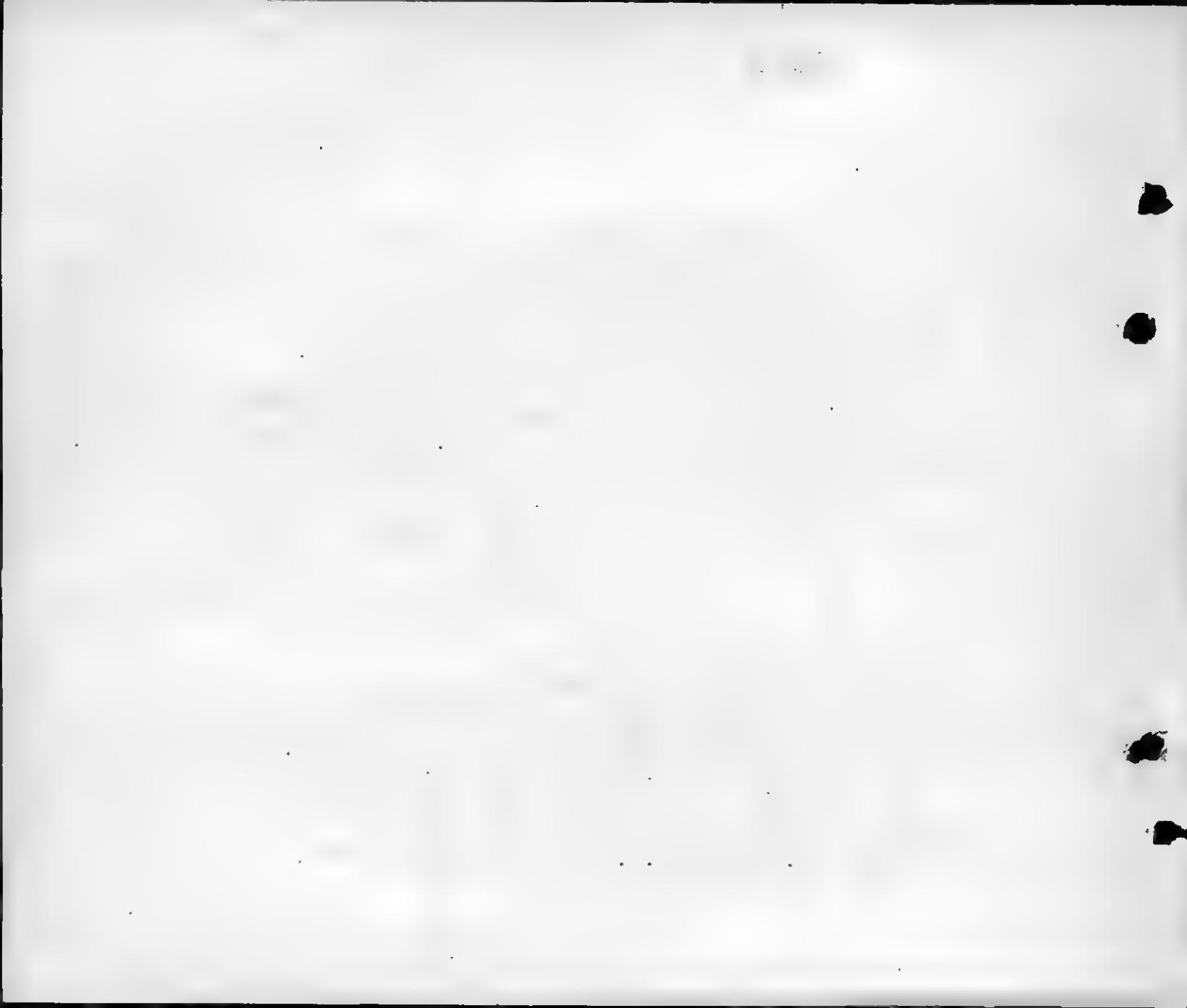
CERTIFICATE OF DEATH

02413

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 48 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1025 Security Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lloyd		First Wesley	Middle Plume	Last	4. DATE OF DEATH February 14	Month	Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1897	9. AGE (In years last birthday) 63 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scaleman	10b. KIND OF BUSINESS OR INDUSTRY Cement	11. BIRTHPLACE (State or foreign country) Elkton Va.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Lewis I. Plume				14. MOTHER'S MAIDEN NAME Rachael M. Hammer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Eugene P. Plume		Address Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale								
434-4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema & fibrosis, severe 3 years								
(c) Due to (b) Pulmonary emphysema & fibrosis, severe 3 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January 31, 1961 to February 14, 1961 , that (I) (we) last saw the deceased alive on February 14, 1961 and that death occurred at 20PM , from the causes and on the date stated above.								
22. SIGNATURE 								
22b. DATE SIGNED February 15, 1961								
22c. PHYSICIAN'S NAME (Type) John H. Kehne, M.D.				22d. ADDRESS Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son								
ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR FEB 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital, or attending physician, and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

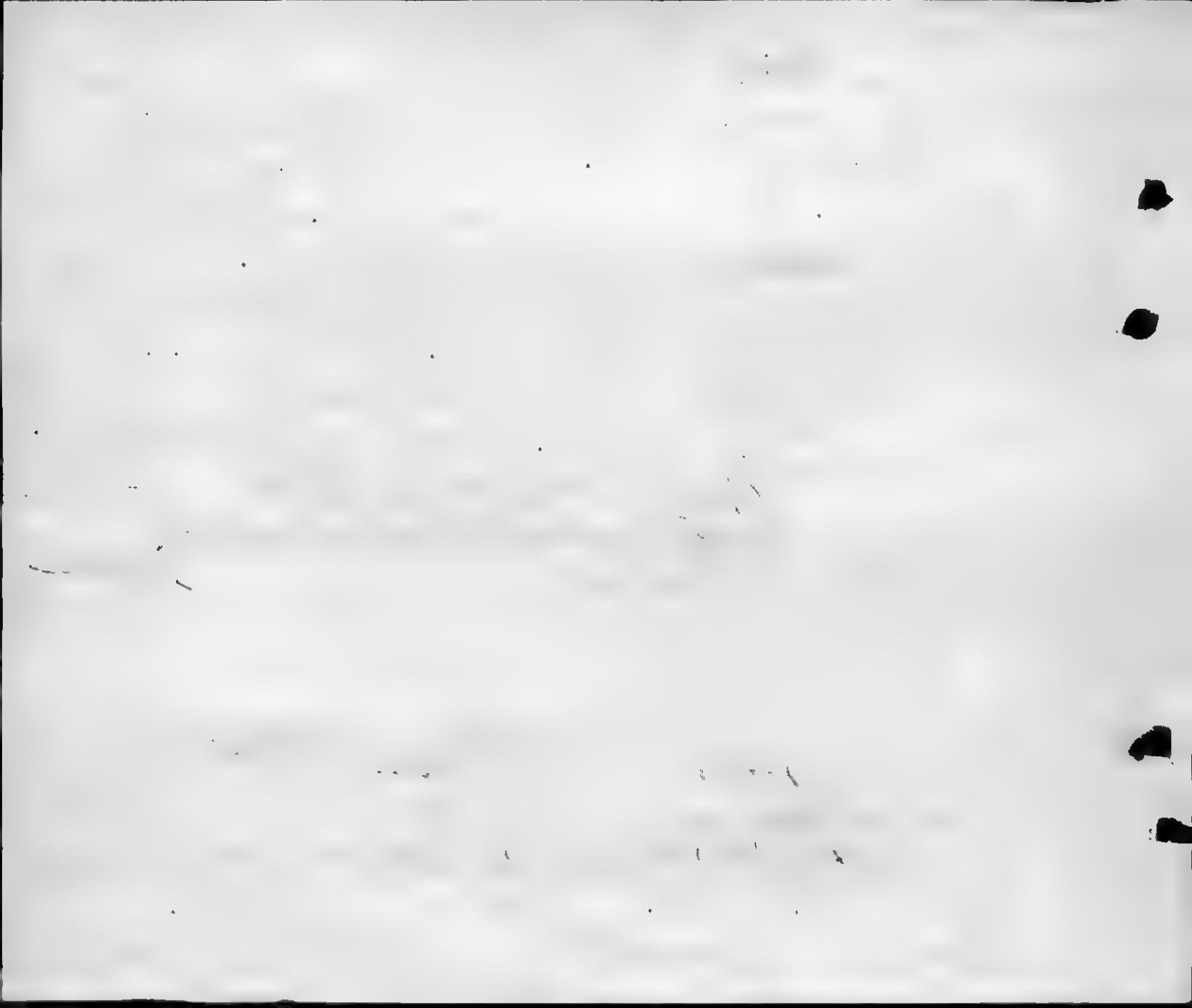
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2444

CERTIFICATE OF DEATH

112460

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and a ve nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)											
Washington		Maryland		25 yrs.		a. STATE											
b. Sharpsburg		c. Sharpsburg (Rural)		d. STREET ADDRESS		b. COUNTY											
d. Sharpsburg Md. RFD #1		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. DATE OF DEATH		e. IS RESIDENCE ON A FARM?											
First		Middle		Last		Month		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		Margaret Louise		Poffenberger		Feb.		Day									
4. SEX		5. COLOR OR HAIR		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. DATE OF BIRTH		8. AGE (In years last birthday)									
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 11 1903		57 yrs.									
9. IF UNDER 1 YEAR		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Months		Housewife		Home		Md.		U.S.A.									
Days		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Hours		Min.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
No		None		Mr. Harvey Cecil Poffenberger RFD #1		Sharpsburg Md.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
						Hour a.m.		White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
						p.m.		19									
21. I certify that (I) (this hospital) attended the deceased from 4/7/61 to 4/8/61, 1961, that (I) (we) last saw the deceased alive on 4/4/61, 1961, and that death occurred 10 A.M. from the causes and on the date stated above.		22a. SIGNATURE		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SEARL VODNE MD		Burial		Feb. 11-61		Mt. View Cemetery		Sharpsburg Md.		FEB 14 '61		Arthur S. Trahan					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		DATE													
Albert Leaf Williamsport Md.																	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2445

112461

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Hagerstown

c. LENGTH OF STAY IN 1b

51 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

R.F.D. # 4

3. NAME OF
DECEASED
(Type or print)

First

Middle

SAMUEL

WALTER

4. SEX

6. COLOR OR RACE

male

white

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Carpenter

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE
OF
DEATH

B. DATE OF BIRTH

February 8, 1892

9. AGE (in years
last birthday)

69 yrs.

10. IF UNDER 1 YEAR
Months

Days

Hours

M. n.

R.F.D. # 4

Last

Month

Dey

Year

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

19. WAS AUTOPSY
PERFORMED?20. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

21. I certify that (I) (this hospital) attended the deceased from

22. SIGNATURE

23c. PHYSICIAN'S
NAME (Type)

24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

26. DATE
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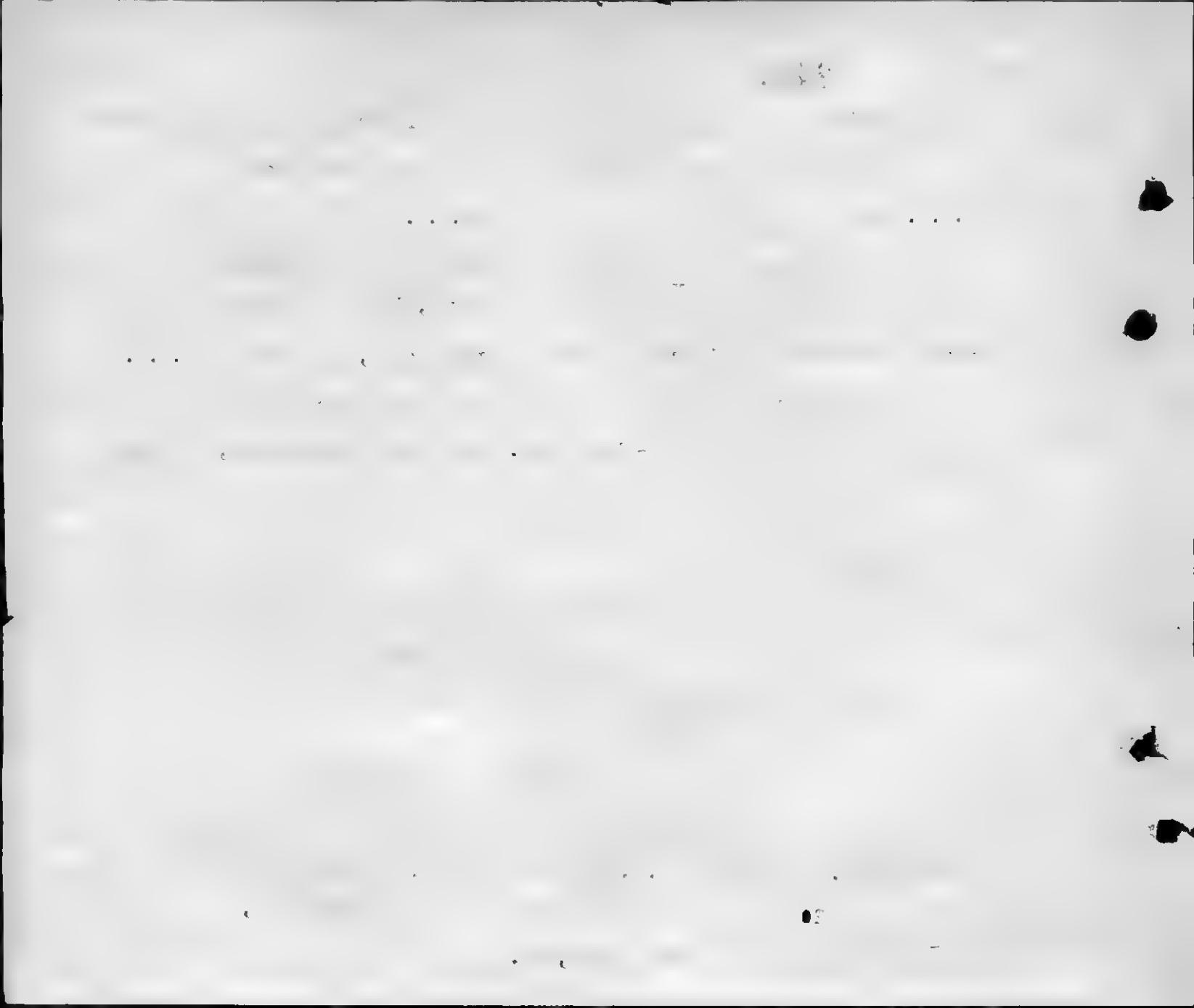
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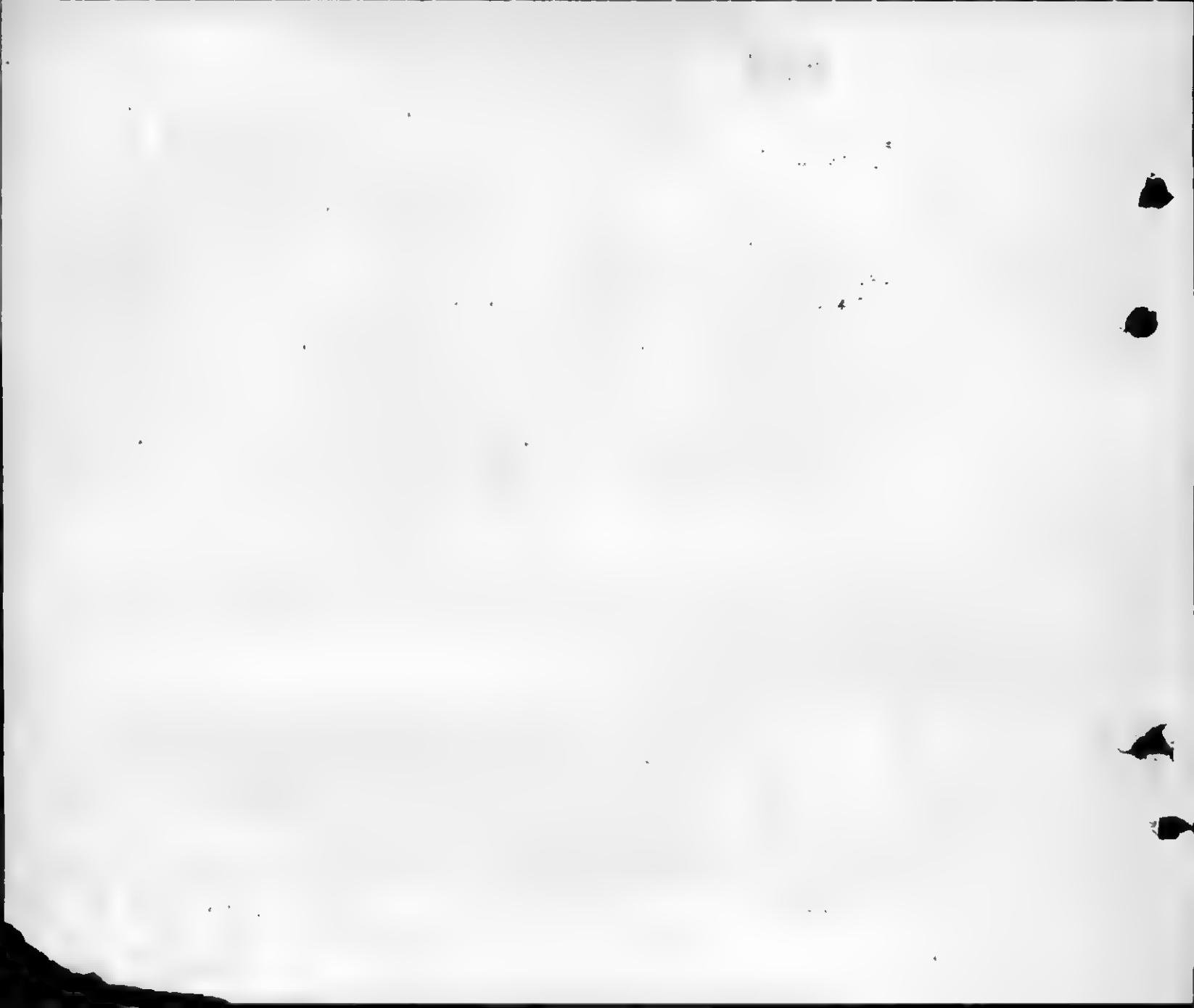
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(12462)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown rural		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home			d. STREET ADDRESS 1044 Corbett St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Howard	Middle Joseph	Last Renner	4. DATE OF DEATH 2	Month 27	Day 19	Year 61
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1879		9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.			12. CITIZEN OF WHAT COUNTRY? 1 SA
13. FATHER'S NAME William Renner				14. MOTHER'S MAIDEN NAME Margaret Luft				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. John Phillips			Address Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 4 mos		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15, 1960</u> to <u>Feb 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 27, 1961</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above			22d. ADDRESS <i>Clear Spring Md</i>			22b. DATE 3/1/61		
22c. PHYSICIAN'S NAME (Type) <i>David R. Brewer</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-61	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town or county) Hagerstown, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				25a. REC'D BY REGISTRAR MAR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss		
VR A1S (4) 15M 9/59				DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02463

2447

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown #2</i>		c. LENGTH OF STAY IN 1b <i>3 wks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Leitersburg</i>		d. STREET ADDRESS <i>1 HAGERSTOWN R.D. 5</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gateway Convalescent</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Ida</i>		First	Middle <i>M.</i>	Last <i>Reynolds</i>	4. DATE OF DEATH <i>Feb 8 1961</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 22, 1870</i>		9. AGE (In years last birthday) <i>90 yrs</i>	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Samuel Martin</i>				14. MOTHER'S MAIDEN NAME <i>Letha Snyder</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>422.1</i> Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterio Sclerotic Cardiac Dis (c) DUE TO Hypostatic Pneumonia 3 days. INTERVAL BETWEEN ONSET AND DEATH 10 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m a. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Leitersburg</i>	(County) <i>Leitersburg</i>	(State) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 5 1961</i> to <i>Feb 8 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb 7 1961</i> , and that death occurred at <i>8445 Wm</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>David R. Brewer</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>2/10/61</i>					
22c. PHYSICIAN'S NAME (Type) <i>David R. Brewer</i>		22d. ADDRESS <i>Clear Spring Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/10/61</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Lutheran Cemetery</i>		23d. LOCATION (City, town, or county) <i>Leitersburg</i>			(State) <i>Maryland</i>
24. FUNERAL-DIRECTOR'S SIGNATURE <i>Walter G. Grove Waynesboro, Pa.</i>				25a. REC'D. BY REGISTRAR <i>Arthur S. Trahan</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>			DATE



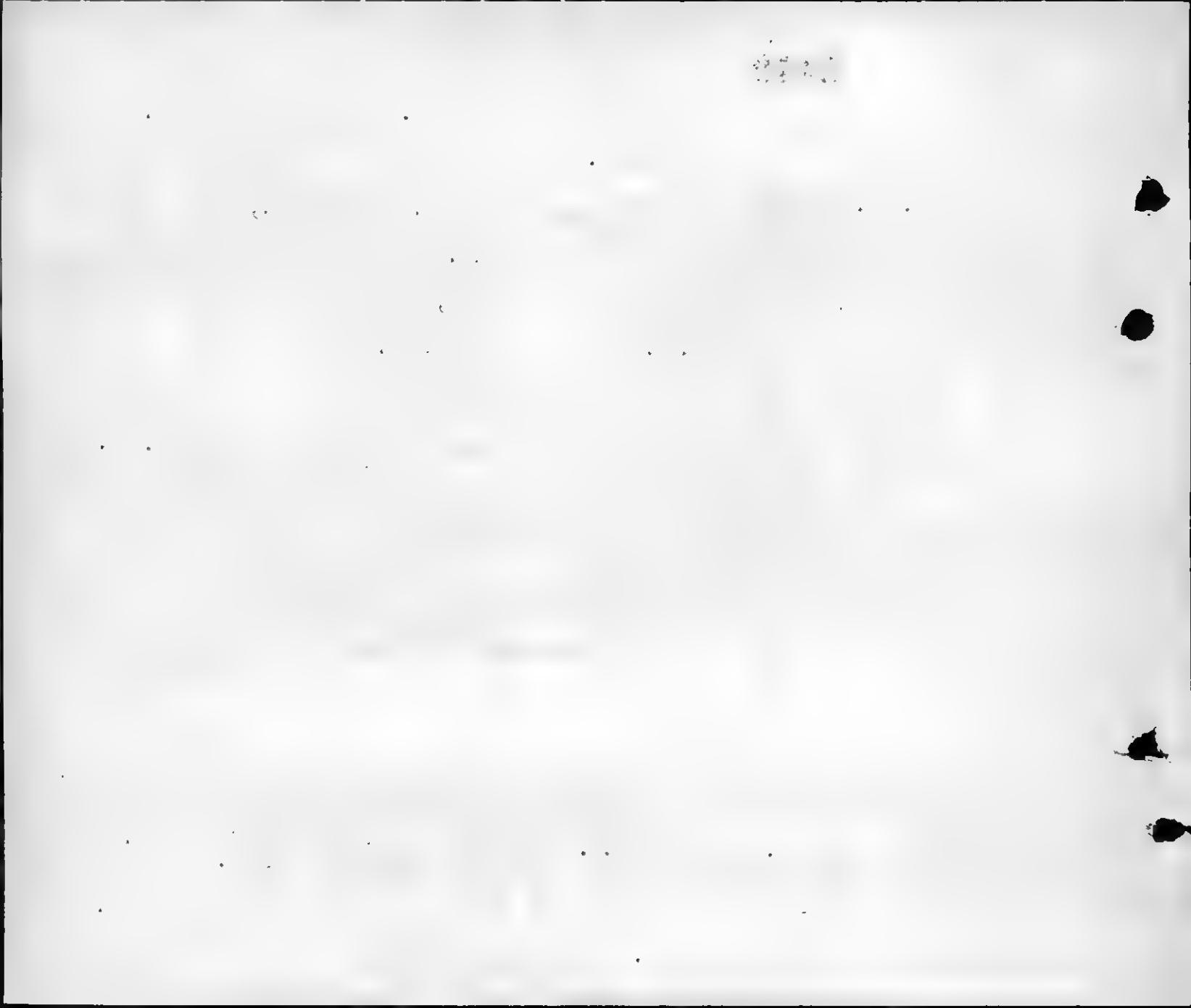
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2448 (12464)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital			d. STREET ADDRESS 609 W. Franklin St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle P	Last Richard Sr.	4. DATE OF DEATH 2	Month	Day 25	Year 1961	
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1883	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10b. KIND OF BUSINESS OR INDUSTRY W. M. R.R.		11. BIRTHPLACE (State or foreign country) Luray, Va.			
13. FATHER'S NAME Hardin Richard				14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Miss Virginia Richard		Address Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>acute left ventricular failure (pulmonary edema)</i> DUE TO <i>+20-C</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atherosclerotic (coronary) heart disease</i> DUE TO <i>+20-C</i> (c) <i>Diabetes mellitus</i>				1 year?				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) <i>Diabetes mellitus</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. While Nat while of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from <i>12/22/1961</i> to <i>12/25/1961</i> , that (II) (we) last saw the deceased alive on <i>12/25/1961</i> , and that death occurred at <i>11:30 AM</i> from the causes and on the date stated above								22b. DATE SIGNED <i>2/27/61</i>
22a. SIGNATURE <i>John H. Hornbaker</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-28-61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown (State) Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 1 '61		
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraiss</i>		



1
MMARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

112465

2449

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1222 Pope AVENUE		d. STREET ADDRESS 11222 Pope AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First PEARL	Middle MAY	Last RIDENOUR
4. DATE OF DEATH	Month FEBRUARY	Day 20	Year 1961
S SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 15-
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MT. LEAF WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? 1222 POPE AVE. HAGERSTOWN MD.	
13. FATHER'S NAME WILLIAM BISHOP		14. MOTHER'S MAIDEN NAME ANNIE WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ALBERT E. RIDENOUR		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 5x1.0		DUE TO (b) None	
DUE TO (c) None		INTERVAL BETWEEN ONSET AND DEATH 6 years.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
None.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 13, 1954 to Feb. 20, 1961 that (I) (we) last saw the deceased alive on Feb. 18, 1961 and that death occurred at 10 P.M. from the causes and on the date stated above.		22b. DATE SIGNED Feb. 21, 1961.	
22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		22d. ADDRESS Hagerstown, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 22, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL BEAVER CREEK CEMETERY		23d. LOCATION (City, town, or county) (State) BEAVER CREEK WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. East		25a. REC'D. BY REGISTRAR ADDRESS Boonsboro MD.	
		25b. REGISTRAR'S SIGNATURE DATE FEB 24 1961	

1
within 24 hours of death. Page 4
may be retained by the hospital or attending physician.2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

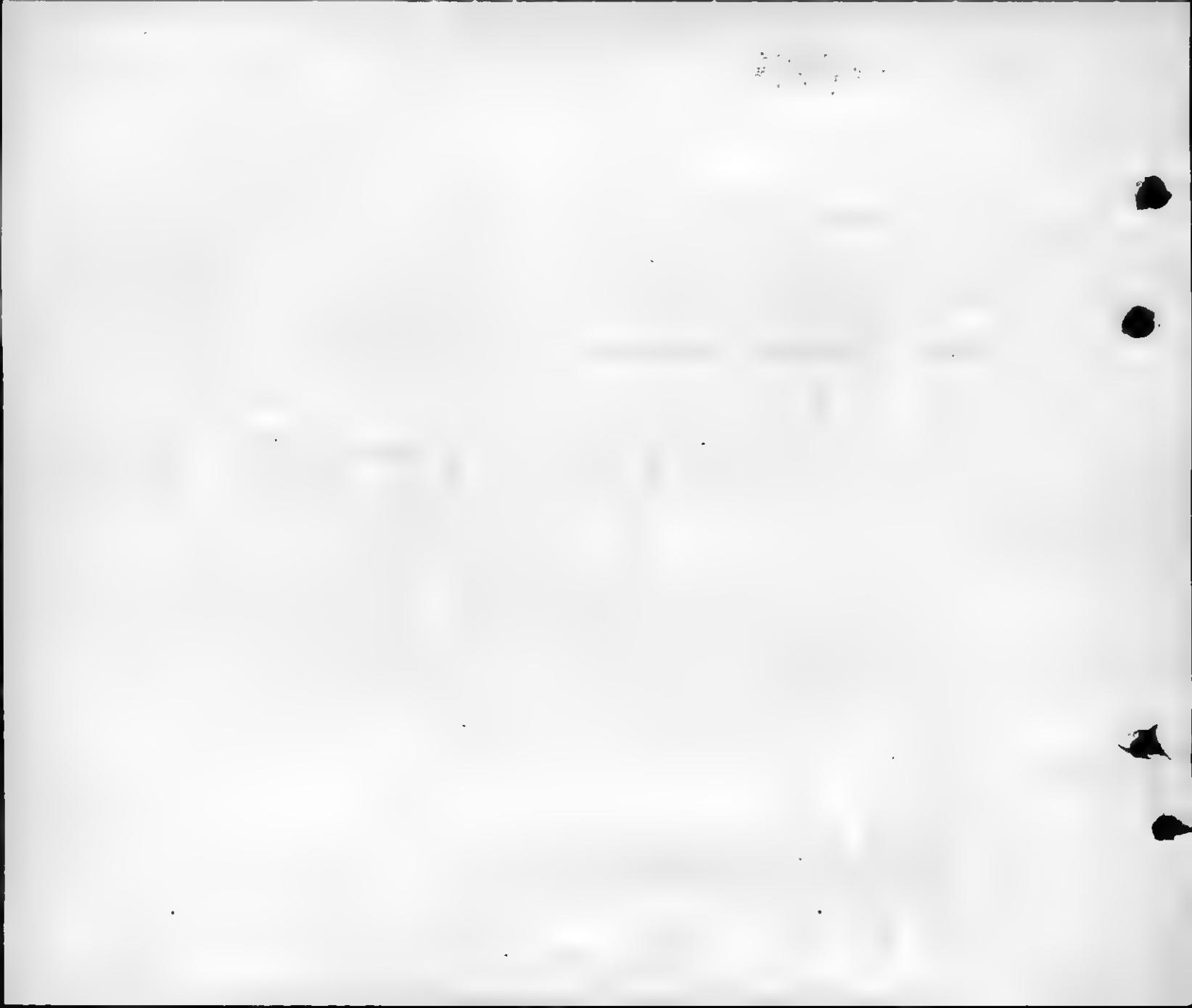
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2450

02450

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>District Columbia</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		c. LENGTH OF STAY IN 1b <i>6 mos. 2 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>5025 Rockwood Parkway</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Williamsport Sanitarium</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Edward</i>	Middle <i>L.</i>	Last <i>Ritter</i>	4. DATE OF DEATH <i>February 12 1961</i>	Month Year	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 4, 1900</i>	9. AGE (In years last birthday) <i>60</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BRANCH MANAGER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Armour & Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Hagerstown, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Ritter</i>		14. MOTHER'S MAIDEN NAME <i>Viola Stone LESHER</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214 09 7576</i>		17. INFORMANT <i>Mrs Henry Burroughs (daughter)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>	
						DUE TO <i>Acute myocardial infarction</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <i>Acute myocardial infarction</i>				DUE TO <i>Acute myocardial infarction</i>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/11/61</i> to <i>2/12/61</i> , that (I) (we) last saw the deceased alive on <i>2/12/61</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Ralph F. Young</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/13/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>RALPH F. YOUNG</i>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 15-61</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Riverview Cemetery</i>		23d. LOCATION (City, town, or county) <i>Williamsport Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Albert Leaf Williamsport Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>FEB 16 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

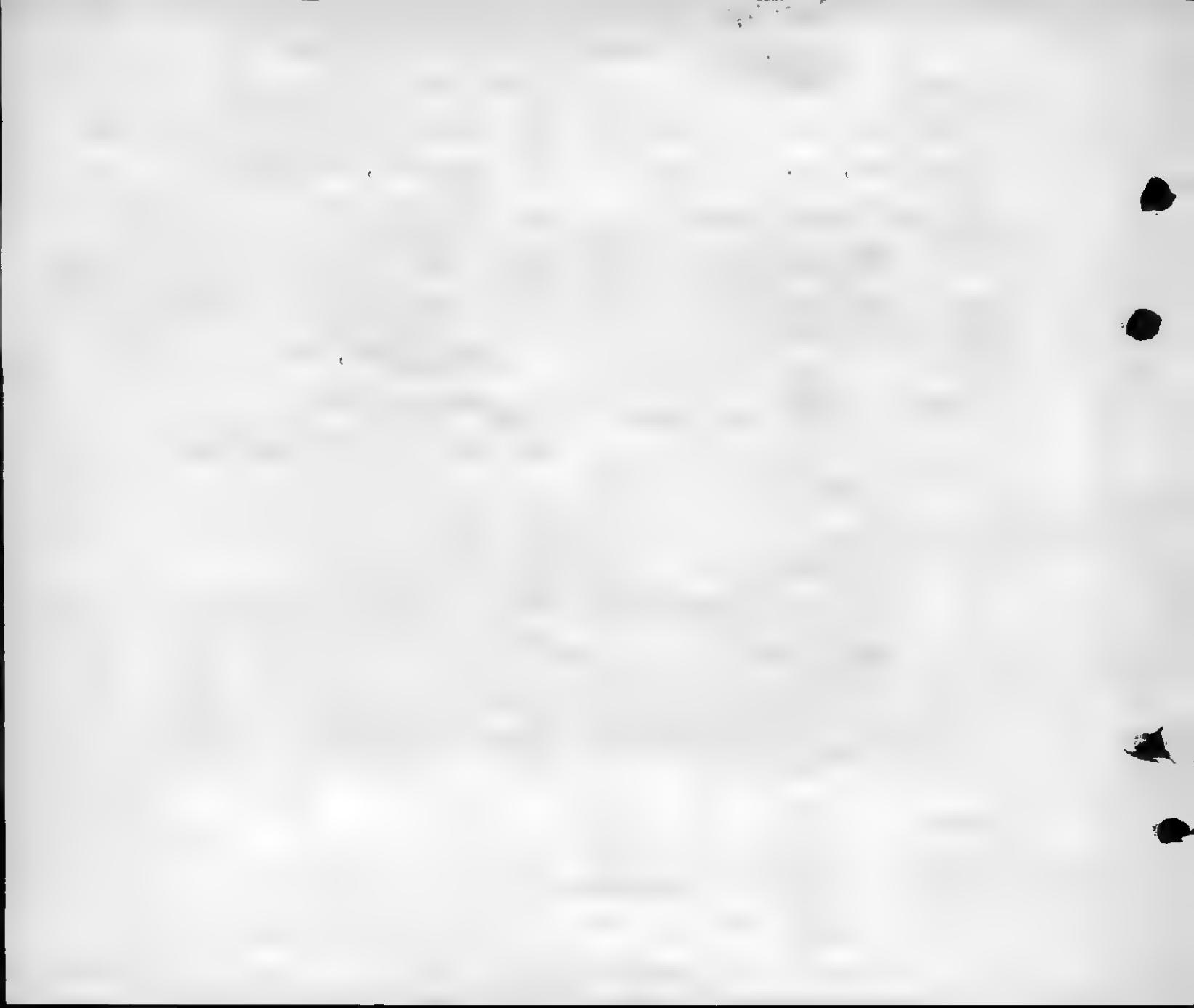
08465

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 461 Park Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 461 Park Place				4. DATE OF DEATH Feb 2 1961		Month Feb	Day 19
3. NAME OF DECEASED (Type or print) Jeffry Lynn		First Jeffry	Middle Lynn	Last Robinson	Year 1961	IF UNDER 1 YEAR Months 18	IF UNDER 24 HRS. Days 18
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 2 1961		9. AGE (In years from birthday) 18	10. IF UNDER 1 YEAR Hours 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Md		12. CITIZEN OF WHAT COUNTRY? Hagerstown, Md	
13. FATHER'S NAME Thomas Robinson		14. MOTHER'S MAIDEN NAME Sadie Bennett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Sadie Robinson 461 Park Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053.4 DUE TO Aspiration of Vomitus INTERVAL BETWEEN ONSET AND DEATH 24 hrs							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sep ticemia		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown	(County) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE J. W. Smith Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/27/61	
EXAMINER'S NAME (Type) J. W. Smith Jr.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 27, 1961		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John B. Watson Jr. Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 1 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, on to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2452

CERTIFICATE OF DEATH

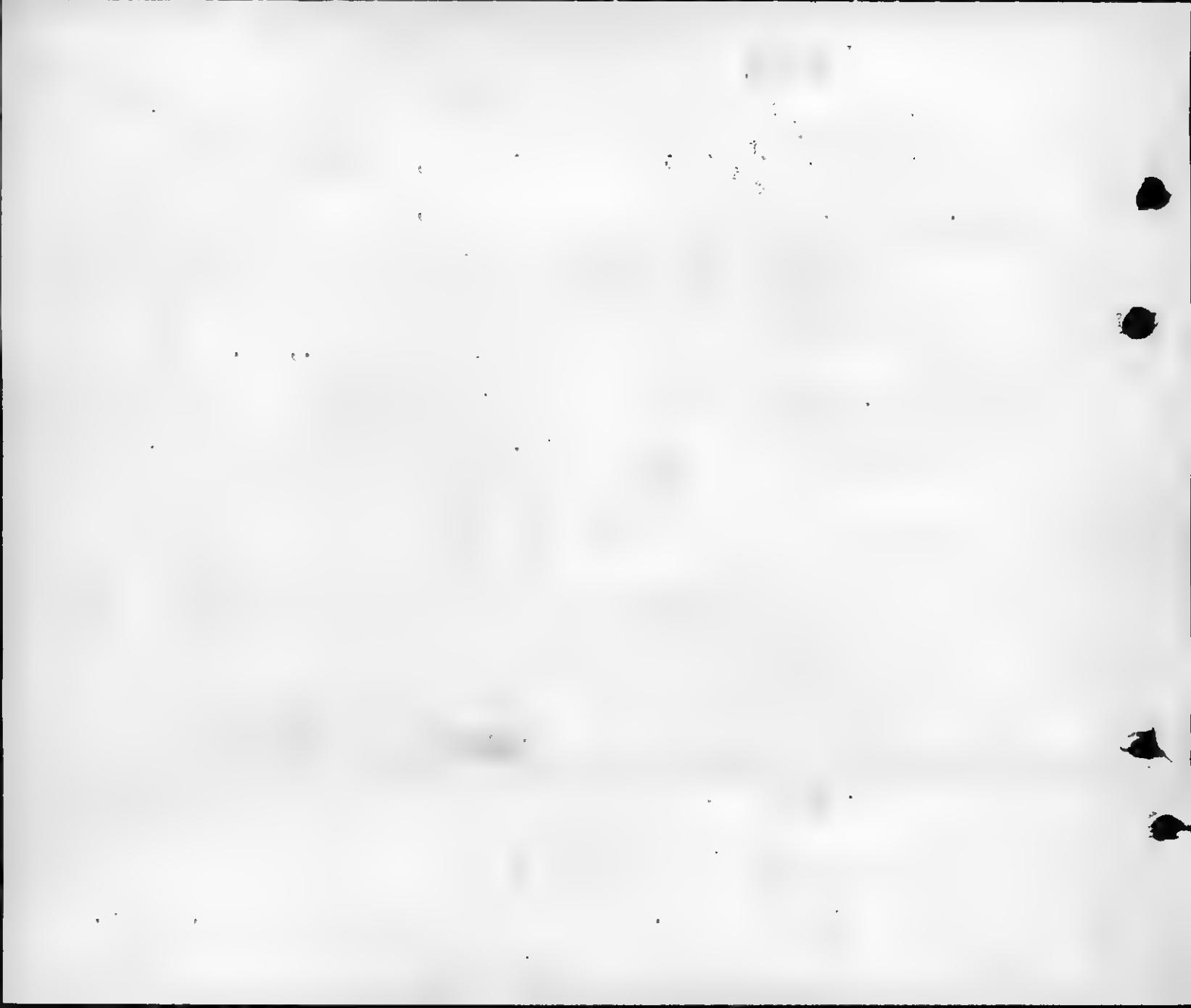
012428

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 1 Hancock				b. COUNTY Washington				
c. LENGTH OF STAY IN 1b Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 1, Hancock				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home, Rural 1, Hancock				d. STREET ADDRESS Rural 1, Hancock				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Amanda	Middle Elizabeth	Last Roby	4. DATE OF DEATH 2 18 19 61	Month 2	Day 18	Year 19 61
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/1874		
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or Foreign country) Washington Co., Md.		
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George A. Bishop		14. MOTHER'S MAIDEN NAME Rebecca Welch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO no		17. INFORMANT Mrs. Magie Verner		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4 Conditons, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg. etc.) 20f. (City or town) 205 Hancock (County) 1961 (State) MD		21. I certify that (I) (this hospital) attended the deceased from Mar 1961 to Feb 18 1961 , that (I) last saw the deceased alive on Mar 1961 , and that death occurred at 105 Hancock M. from the causes and on the date stated above		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>M. Shaffer</i> Hancock MD		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 105 Hancock MD		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
23b. DATE THEREOF 2/22/61		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet (old)		23d. LOCATION (City, town, or county) Rural Hancock, Md.		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Howard & George Hancock md</i>		ADDRESS <i>105 Hancock</i>		25a. REC'D BY REGISTRAR FEB 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

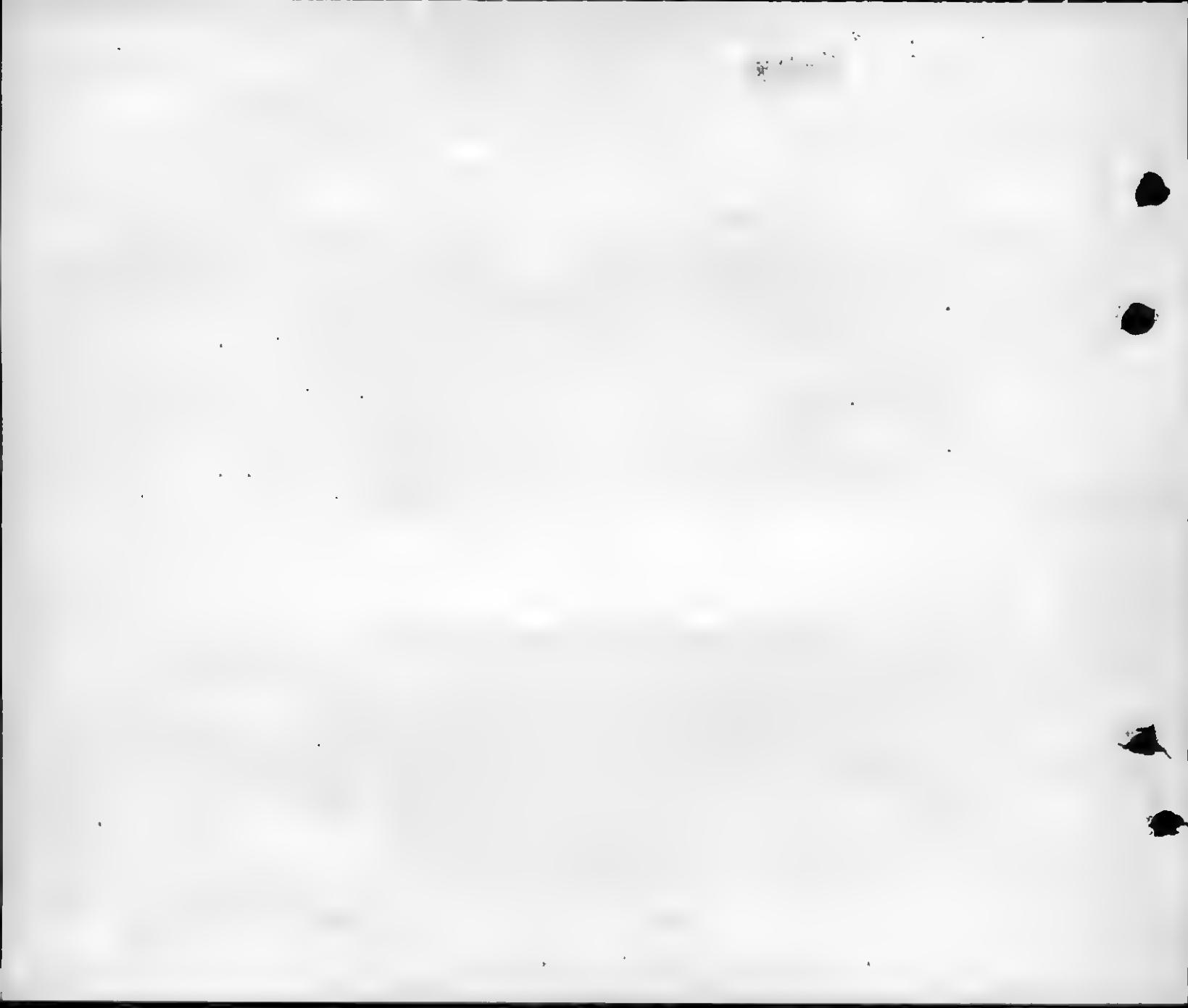
2458

CERTIFICATE OF DEATH

303

102463

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 240 So. Potomac St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. DATE OF DEATH Feb 22 1961		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KLEORA		First	Middle	Last	Month	Day	Year
4. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 17 1878	9. AGE (In years from birth) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Sands		14. MOTHER'S MAIDEN NAME Eliza H. Bomberger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs Cecil Clark 818 Pleasantville Rd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3-20 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO subarachnoid hemorrhage		Briarcliff Manor N.Y.		13 days	
		(b) Arteriosclerosis				4 yrs	
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dermatofibromas of bladder						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19 1961 to Feb 22 1961, that (I) (we) last saw the deceased alive on Feb 22 1961, and that death occurred at 2 PM, from the causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 2/23/61	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Potomac St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/27/61		23c. NAME OF CEMETERY OR CREMATORIAL Will Scatter ashes near Smithsburg Wash Co Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2454

CERTIFICATE OF DEATH

02450

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#3		c. LENGTH OF STAY IN Tb 3 Yrs		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Conv. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS Kneisley Apts			
3. NAME OF (Type or print)	First HARRY	Middle LADISON	Last SAUNDERS	4. DATE OF DEATH	Month Feby	Day 19	Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7 1899	9. AGE (in years last birthday) 61	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Minutes 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakenan		10b. KIND OF BUSINESS OR INDUSTRY W. L. R. h.		11. BIRTHPLACE (State or foreign country) Downsville Wsh Co Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Saunders		14. MOTHER'S MAIDEN NAME Mary Hutzell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 14-09-6301		17. INFORMANT Mrs Alice Bussard		Address 1932 Gay St Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4120.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 1 day					
DUE TO Arteriosclerotic heart disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardi. Dis., Old tuberc. & bronch.						19. WAS AUTOPSY PERFORMED? NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) date							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1135 POTOMAC AVENUE, HAGERSTOWN, MD.		20f. (City or town) Hagerstown		(County) Washington	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 18 Aug 1956 to date , that (I) (he) last saw the deceased alive on Nov 1960 , and that death occurred at 3 AM , from the causes and on the date stated above.									
22a. SIGNATURE Richard T. Binford		22b. DATE SIGNED 3/20/61		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		22d. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/61		23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery		23d. LOCATION (City, town, or county) Boonsboro Wsh Co Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE Other times			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02401

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Md. b. COUNTY Wash.	
Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				rural Smithsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		RFD 1			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
		Walter	Leonard	Schamel	Month Feb. 14, Day 19 61
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, <small>Int. b. today</small>)
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 31, 1909	52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
salesman		lumber company		Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Robert P. Schamel		Maude Adam			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
yes		217-32-5714		Mrs. Myrtice Schamel, Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH			
		Instant			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>A. E. Ditto</i>		DATE SIGNED 2-15-61			
EXAMINER'S NAME (Type) Dr. E. E. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-17-61		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
				22d. LOCATION (City, town, or county) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 21 '61	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please enclose the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

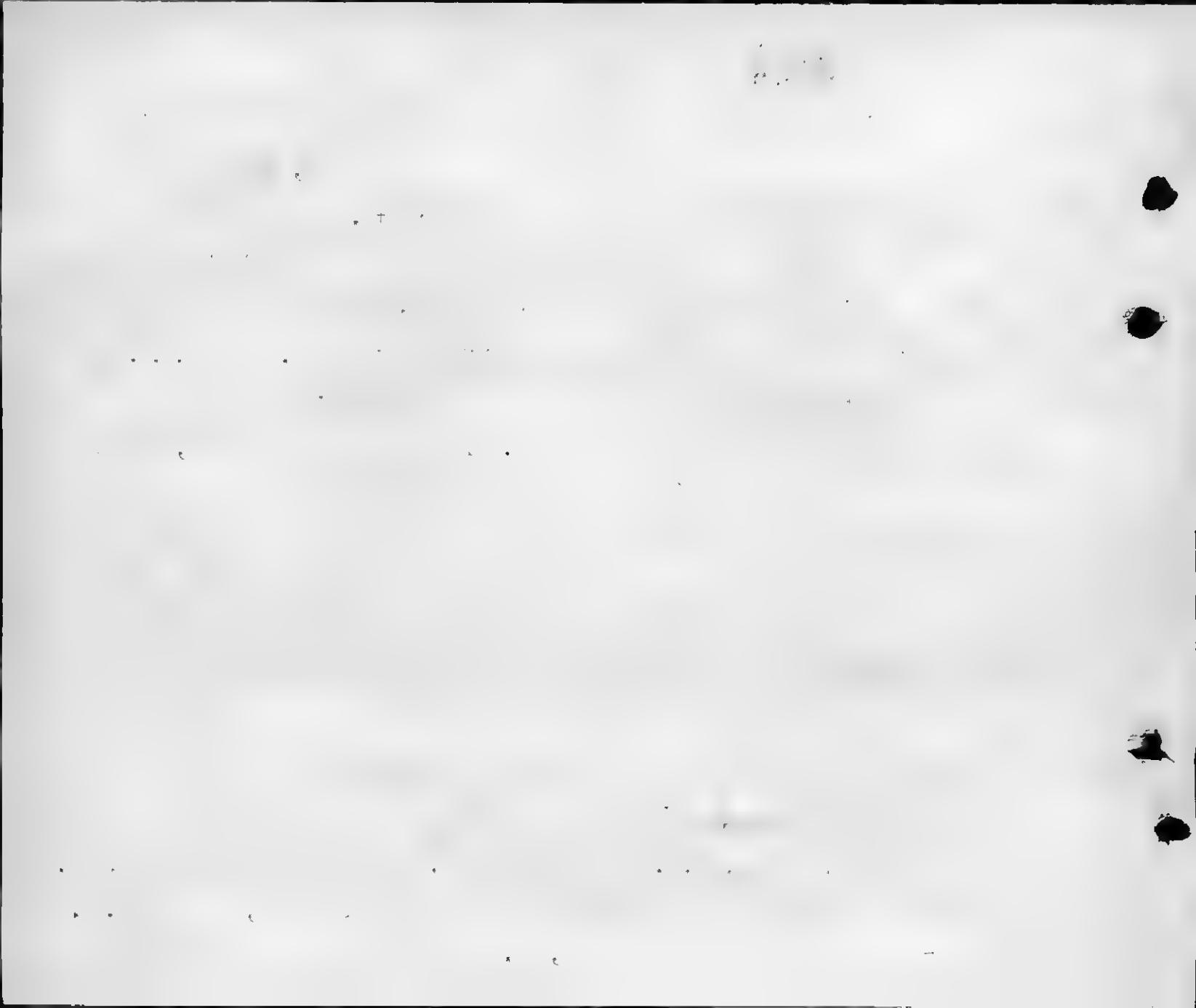
2456

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND c. LENGTH OF STAY IN 1b 3 years		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS Moller Apts.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA		First ANNA	Middle LOUISE	Last SCHMIDT	4. DATE OF DEATH Month February Day 3 Year 1961
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH September 16, 1870	9. AGE (in years last birthday) 90 yrs. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penn.	
13. FATHER'S NAME Gustav Senff		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT none		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis (b) DUE TO Arteriosclerosis (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 136 N. Potomac St., Hagerstown, Md.	(County) D.C. (State)
21. I certify that (I) (this hospital) attended the deceased from 8/12/60 , 19, to 2/3/61 , 19, that (I) (we) last saw the deceased alive on 1/9/61 , 19, and that death occurred at 1:10 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 2/4/61			
22a. SIGNATURE Edward N. Weeks, M.D.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Edward N. Weeks, M.D.		22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/7/1961	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City, town or county) Washington, D.C. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home Hagerstown, Md.		ADDRESS R. Franklin Suter	25a. REC'D BY REGISTRAR DATE FEB 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 1a, 1b, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61 et

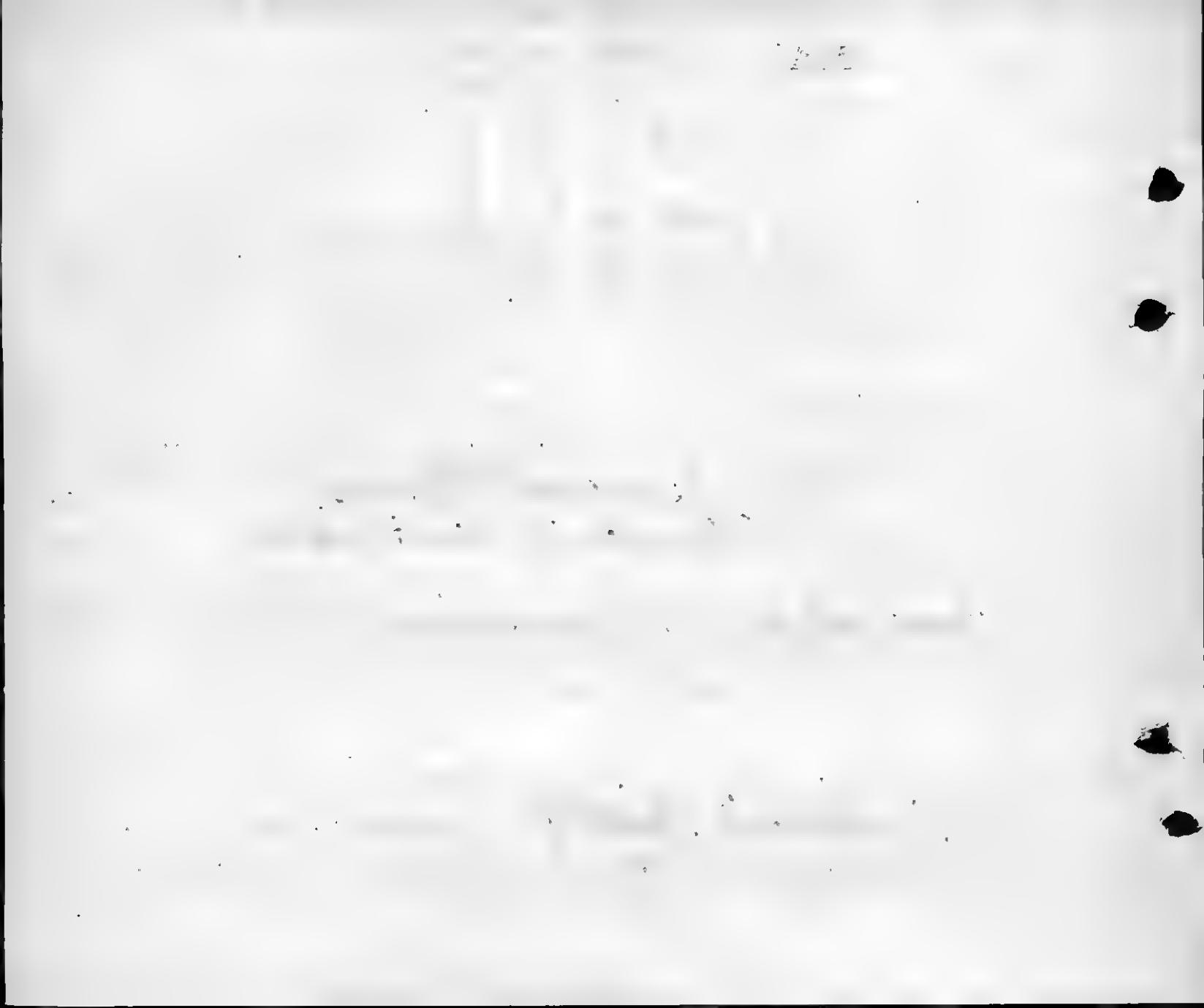
2457

CERTIFICATE OF DEATH

Reg. Dist. No.

112403

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Smithsburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Home		d. STREET ADDRESS RD # 1				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First MARY	Middle ANI	Last SCHWENK			
4. DATE OF DEATH	Month Feb.	Day 19	Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1879			
9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME George Miller		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT Mrs. Chas. Alter, 126 Hamilton Ave., Waynesboro,	Address Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Cerebral thrombosis DUE TO (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 3 weeks, years,						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Undernutrition; Paroxysm						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 29 JULY 1959, to 19 FEB. 1961, that I last saw the deceased alive on 27 JANUARY 1961, and that death occurred at 8A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard T. Binford, 1135 POTOMAC AVE., HAGERSTOWN, MD. 2/20/61						
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D.				
PHYSICIAN'S NAME (Type)		HAGERSTOWN, MARYLAND.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/23/1961	22c. NAME OF CEMETERY OR CREMATORIUM Eastville Church Cemetery		22d. LOCATION (City, town, or county) Eastville (State) Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE S. Martin, Jr.		ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR FEB 23 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02404

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Charles						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		d. STREET ADDRESS OT X-2						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MD. STATE Hosp.		d. STREET ADDRESS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Thomas Murray		First	Middle	Last	4. DATE OF DEATH 2 19 1961	Month	Day	Year				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5, 1902	9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months 5	Days 0	Hours 0				
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molders Helper		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Charles Seger		14. MOTHER'S MAIDEN NAME JUNE M. HUNT		15. INFORMANT Mrs. CARTHA Seger, WALDORF, MD.		Address						
16. IS WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH 5 days										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 70		DUE TO lobular Pneumonia		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Carcinoma of kidney with abdominal carcinomatosis		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from May 19, 1960 to Feb. 19, 1961 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Feb. 19, 1961 , and that death occurred at 9:30 A.M. from the causes and on the date stated above		22a. SIGNATURE Young E. Chun		22b. ADDRESS Young E. Chun		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> Feb 19, 1961 DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) Young E. Chun		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-22-61		23c. NAME OF CEMETERY OR CREMATORIAL St Peters		23d. LOCATION (City, town, or county) Waldorf, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Hunter Funeral Home, Waldorf, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 24 '61		25b. REGISTRAR'S SIGNATURE C. Sims S. Kraus						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2459

CERTIFICATE OF DEATH

112405

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF DECEASED
(Type or print)

Gerald

Middle

Lee

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. STREET ADDRESS

304 Greendale Drive

Last

4. DATE

OF

DEATH

Feb

Month

Day

Year

b. IS RESIDENCE
ON A FARM?

YES NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None - Infant

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Hagerstown, Md.

13. FATHER'S NAME

William G. Shank

15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mr. W.G. Shank

304 Greendale Dr. Hagerstown, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

761.0
Condition, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Respiratory Failure
Anemia
Face presentation

INTERVAL BETWEEN
ONSET AND DEATH

11 days

11 days

11 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Part 18)

20c. TIME OF INJURY
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2/12 1961, to 2/13 1961, that (I) (we) last saw the deceased alive on 2/12 1961, and that death occurred at 10:30 A.M. from the causes and on the date stated above.

22. SIGNATURE

George Jennings

22c. PHYSICIAN'S
NAME (Type)

George Jennings

ATTENDING
M.D. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

22b. DATE
SIGNED
2/13/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Rest Haven Funeral Chapel

Hagerstown, Md.

25a. REC'D BY REGISTRAR

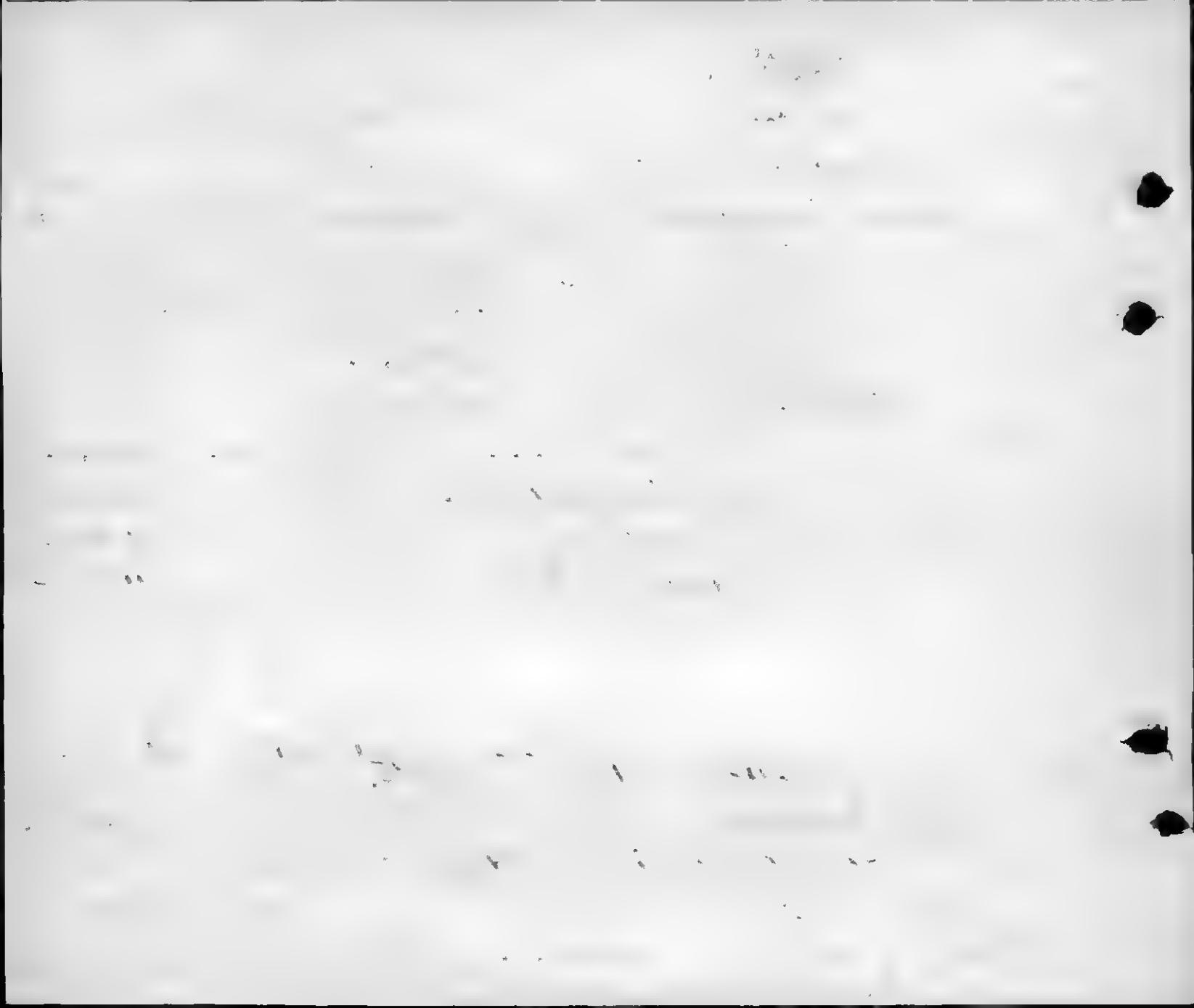
DATE

25b. REGISTRAR'S SIGNATURE

DATE

Arthur S. Thomas

20 81262 XV4



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2460

Item 6 FEB 1961

CERTIFICATE OF DEATH

02400

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		c. LENGTH OF STAY IN 1b <i>9 months</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>West Virginia</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Williamsport Sanitarium</i>		e. STREET ADDRESS <i>512 Samuel St.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <i>Minnie</i> (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 1, 1896</i>	9. AGE (In years last birthday) <i>84</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Phillipi W. Va</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>John Talbott</i>	14. MOTHER'S MAIDEN NAME <i>Augusta Hamrick</i>
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT C Address
--	-------------------------	----------------------------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>331X</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	
DUE TO (b) DUE TO (c)	
Cerebral vascular accident 30 min Generalized Atherosclerosis 15 yrs	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>none</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from <i>July 1960</i> to <i>Feb 4, 1961</i> that (I) (we) last saw the deceased alive on <i>Feb 1, 1961</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above
--

22. SIGNATURE <i>M. E. Burkitt</i>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>1961</i>
22c. PHYSICIAN'S NAME (Type) <i>M. E. Burkitt</i>	22d. ADDRESS <i>Williamsport Md</i>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>2/7/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>ZION</i>	23d. LOCATION (City, town, or county) <i>CHARLES Town W. Va.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Scott F. Minnich & Son</i>	ADDRESS <i>Hagerstown, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>FEB 10 '61</i>	25b. REGISTRAR'S SIGNATURE <i>J. S. Kline</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02407

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 169 Greenberry Rd.		d. STREET ADDRESS 169 Greenberry Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF (Type or print) Coreen		First	Middle
		Shull	Last
4. DATE OF DEATH		Month	Day
		February	21, 1961
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> August 26, 1956
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9. AGE (In years last birthday) 4 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Franklin, Penn.	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME James N. Shull		14. MOTHER'S MAIDEN NAME Marie McGill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. James N. Shull Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 192.4 DUE TO Encephalism		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		10 MOS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/11/1960, to 2/21/1961, that (I) (we) last saw the deceased alive on 2/21/1961, and that death occurred at 11:30 PM, from the causes and on the date stated above		22a. SIGNATURE Richard A. Young M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 2/22/61	
22c. PHYSICIAN'S NAME (Type) Richard A. Young		22d. ADDRESS Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-24-61 23c. NAME OF CEMETERY OR CREMATORIAL Sunset Hill Mem. Cem 23d. LOCATION (City, town, or county) Franklin (State) Penn	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Ninnick & Son		ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR FEB 24 '61 25b. REGISTRAR'S SIGNATURE Charles L. Young



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

112408

2462

Item 9 Film 6282

3/7/61

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS 553 SALEM AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Abbie	Middle May
4. DATE OF DEATH Month 2		5. SEX FEMALE	Middle Initial SMITH
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARCH 1885 -	9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MD.
13. FATHER'S NAME DALLIS HINER		14. MOTHER'S MAIDEN NAME ELLA McAFFEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO 214-09-6692	17. INFORMANT MR. HARRY SMITH 553 SALEM AVE. HAGERSTOWN, MD.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH One week	
Arteriolar Nephrosclerosis Hypertensive vascular disease		unknown	
DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last.		Ten years	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cerebral thrombosis	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 23</u> 1960 to <u>Feb. 24</u> 1961. That (I) (we) lost saw the deceased alive on <u>Feb. 24</u> 1961 and that death occurred at <u>5:00</u> AM, from the causes and on the date stated above.		22b. DATE SIGNED Feb. 24, 1961	
22a. SIGNATURE Young E. Chun		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. ADDRESS 1500 Penna Ave, Hagerstown, MD
22c. PHYSICIAN'S NAME (Type) Young E. Chun			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/27/61	23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL
24. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK		ADDRESS CLEAR SPRING, MD.	23d. LOCATION (City, town or county) HAGERSTOWN, MD. (State)
			25a. REC'D BY REGISTRAR FEB 28 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

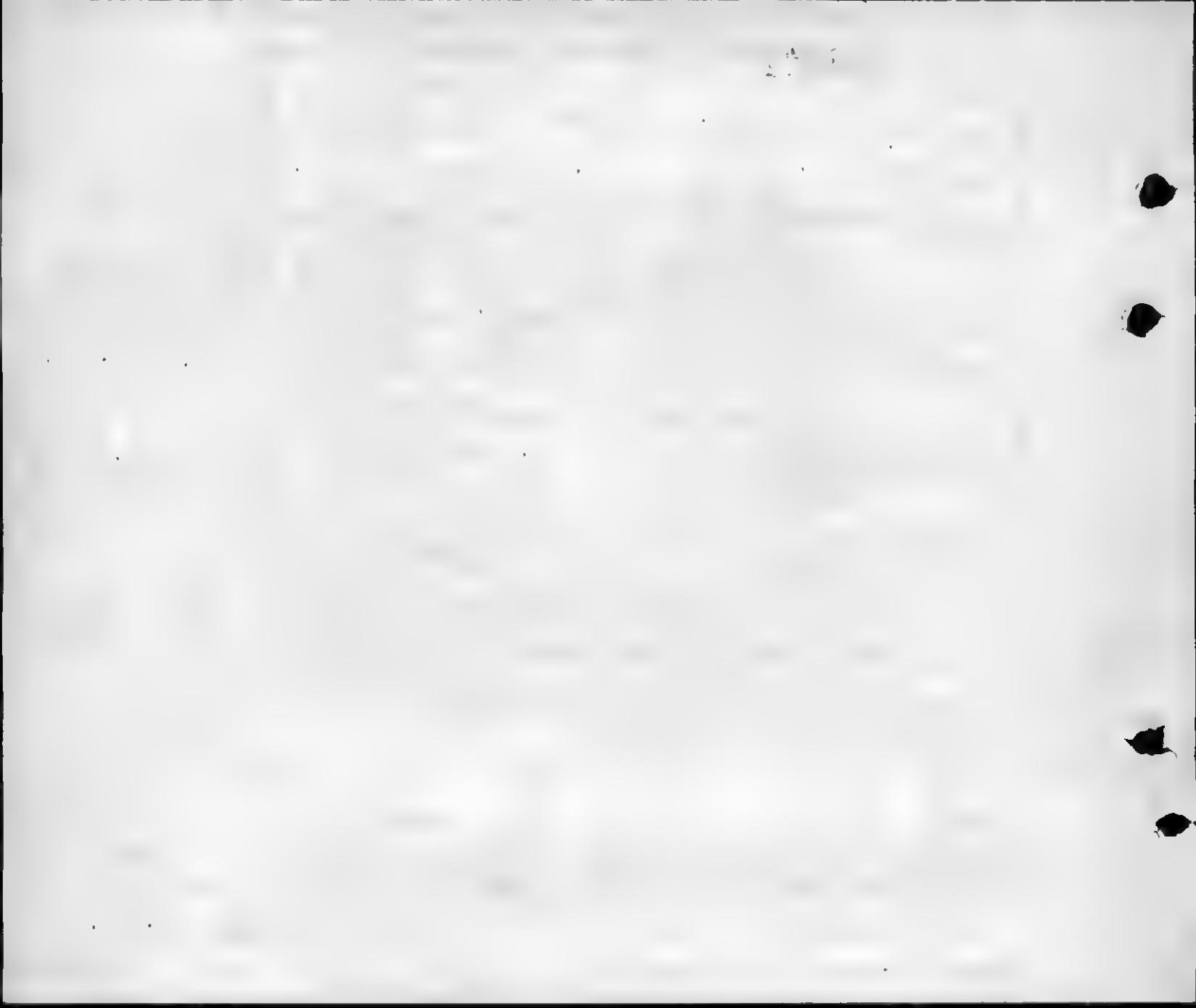
2463 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 112403

1. PLACE OF DEATH a. COUNTY		Washington Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STATE Maryland b. COUNTY Washington	
Smithburg Rt. #3		1 yr.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Holiday Acres		Holiday Acres			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
Etta Leona Smith					February 15 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 13, 1894	66 yr. 66 days 00 hours 00 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Myersville Fred. Co. Md. U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Kline		Laura Dipple		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Mrs. Evelyn Flory Smithburg Rt. #3	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Autumn Seizure Heart Disease 5 yrs			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 2/16/61			
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/61		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Andrew K. Coffman Hagerstown, Md.		24a. REC'D BY REGISTRAR FEB 20 '61 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thrall	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, with the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

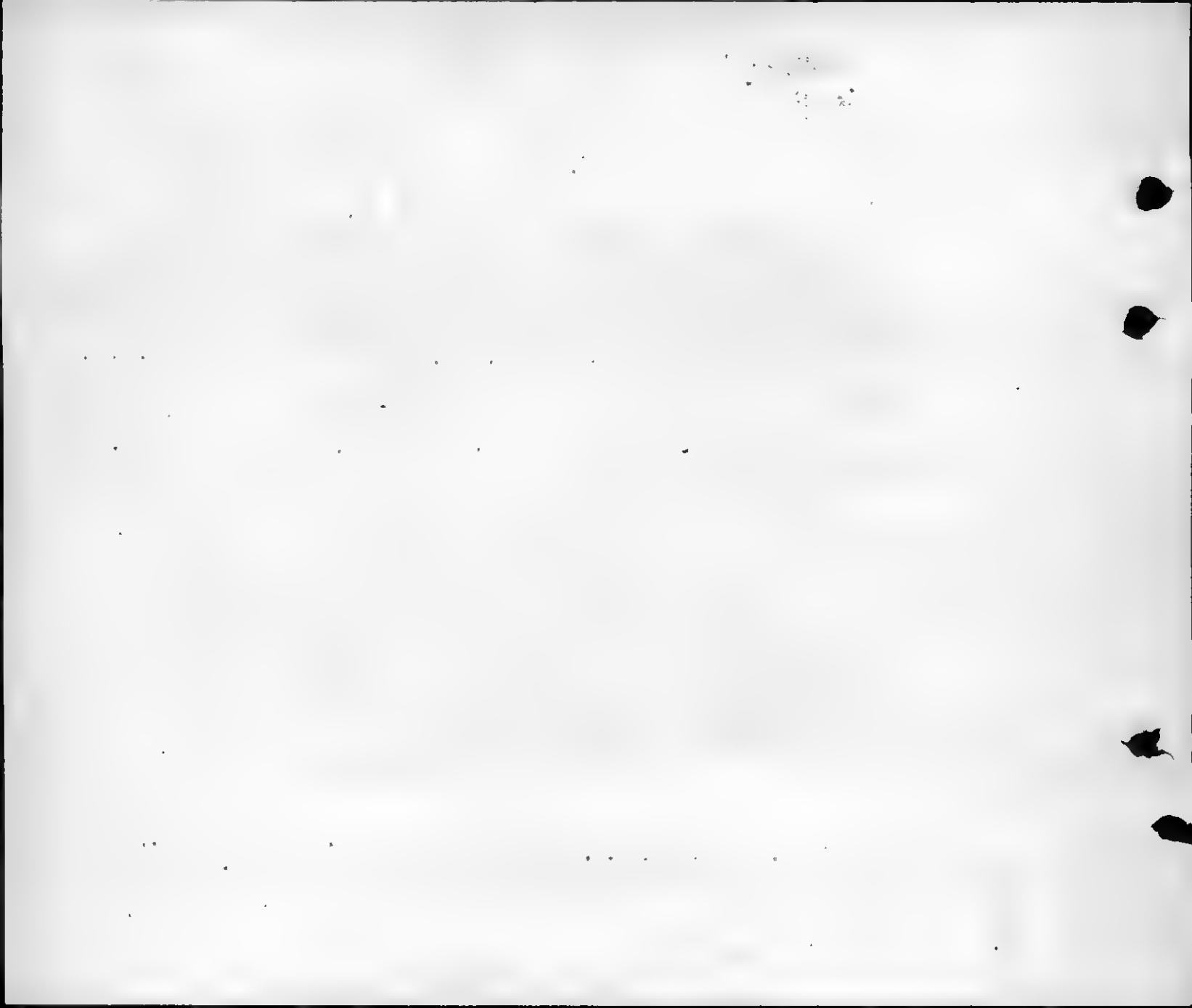
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2464 02460

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERTSTOWN		c. LENGTH OF STAY IN lb 40 YRS.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JOSLPH	Middle MICHAEL	4. DATE OF DEATH FEBRUARY 16 1961				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/1901				
9. AGE (in years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 5 Days 9 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CABINET MAKER FURNITURE MFG. CO.		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA					
13. FATHER'S NAME HARRY SMITH		14. MOTHER'S MAIDEN NAME MARY YEAGER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-1858					
17. INFORMANT MRS. NELLIE G. SMITH		Address HAGERTSTOWN MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
Acute dilation of heart Atherosclerotic heart disease & congestive heart failure							
INTERVAL BETWEEN ONSET AND DEATH ? few minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 2/16 1961 , and that death occurred at 7:45 AM from the causes and on the date stated above.				6-28 1957 to 2-16 1961			
22a. SIGNATURE John H. Hornbaker				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2-17-61	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22d. ADDRESS 154 W. Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/18/61		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ROSE HILL CEM.		23d. LOCATION (City, town, or county) HAGERTSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Horneant Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE FEB 20 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4

may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

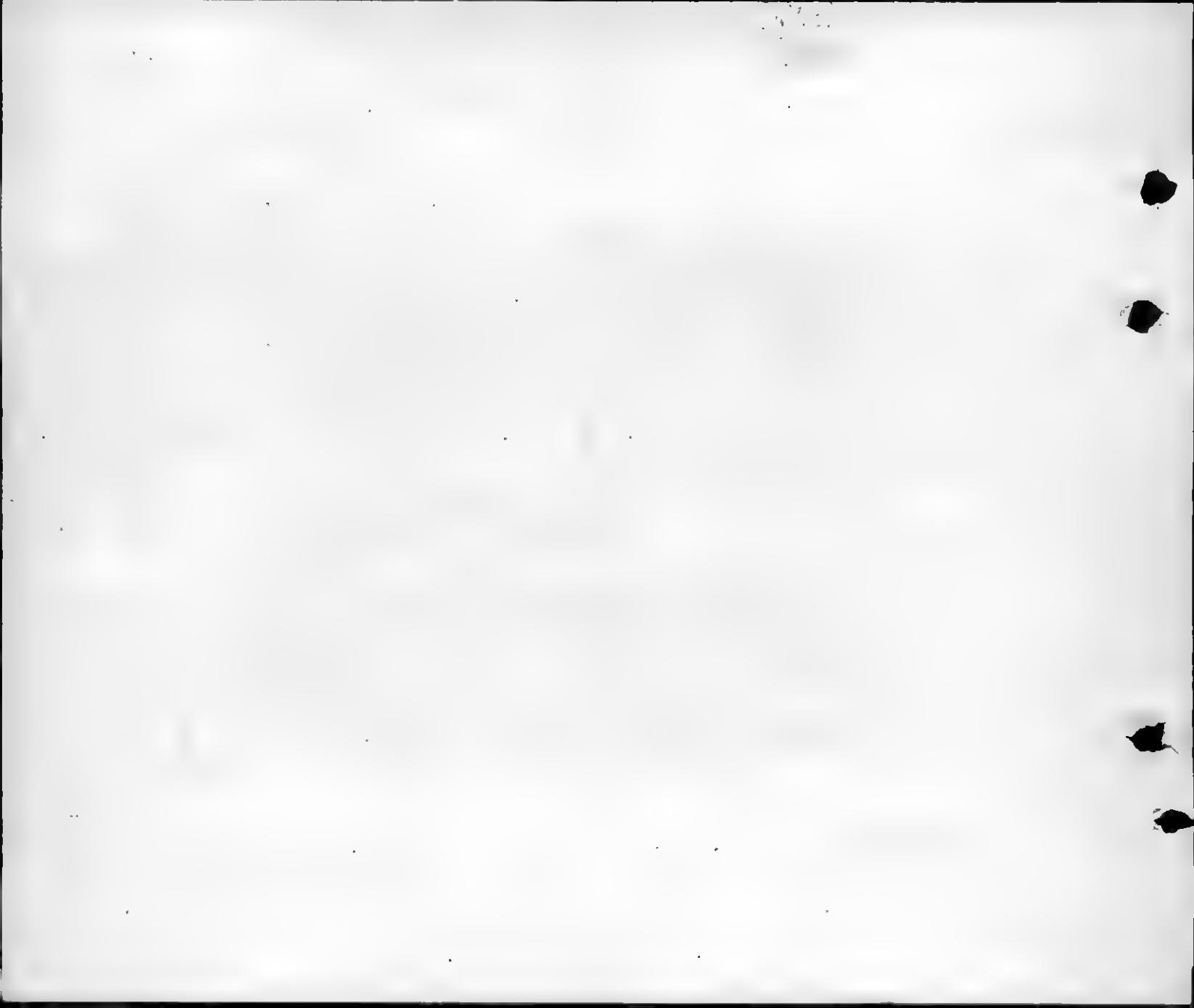
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2465

CERTIFICATE OF DEATH

02451

1. PLACE OF DEATH o COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS 200A Taylor Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Maude	Middle May	Last Snook	4. DATE OF DEATH February	Month Day Year 28 19 61
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1889	9. AGE (In years to birthday) 71 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Church Hill, Md.	
13. FATHER'S NAME Bradford Wolf			14. MOTHER'S MAIDEN NAME Eliza Delauder		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-09-9037		17. INFORMANT Mrs. Eleanor Raidt	
				Address Hagerstown, md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cholestatic nephrosis Carcinoma of gall bladder					
INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
21. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1961, to Feb. 28, 1961, that (I) (we) last saw the deceased alive on Feb. 28, 1961, and that death occurred at M, from the causes and on the date stated above		(City or town) (County) (State)			
22a. SIGNATURE John D. Turco		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3-1-61	
22c. PHYSICIAN'S NAME (Type) John D. Turco, M.D.		22d. ADDRESS 302 N. Potomac Street-Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-61		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR d. DATE MAR 6 '61	
				25b. REGISTRAR'S SIGNATURE John S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE, MARYLAND																					
CERTIFICATE OF DEATH																					
Item 2 FilmG-23-3-1-ct 302 024-2																					
1. PLACE OF DEATH a. COUNTY Washington			MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)			a. STATE Maryland			b. COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 3 Weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			d. STREET ADDRESS 113 S. Mulberry St. Fuhpney 77 Keedys House			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital			e. First VIOLA Middle SNYDER			f. Last SNYDER			g. DATE OF DEATH February 23 1961 19												
3. NAME OF DECEASED (Type or print) KATIE			4. SEX Female			5. COLOR OR RACE White			6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7. DATE OF BIRTH December 5 1880			8. AGE (In years last birthday) 80 yrs			9. IF UNDER 1 YEAR Months Days Hours Min		10. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (State or foreign country) Md Keedysville Wash Co			12. CITIZEN OF WHAT COUNTRY? USA												
13. FATHER'S NAME Hiram Snyder			14. MOTHER'S MAIDEN NAME Lucinda Gouff			15. SOCIAL SECURITY NO No			16. INFORMANT J. Franklin Davis 112 Randolph Ave			17. INFORMANT Address Hagerstown, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO cause (a), stating the under- lying cause last. (c)			19. INTERVAL BETWEEN ONSET AND DEATH 1 yr +			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Pulmonary Embolism, Arteriosclerotic heart disease			21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (I) (the physician) attended the deceased from 21 Nov. 1959, to 23 FEB. 1961, that (I) (the physician) last saw the deceased alive on 23 FEB. 1961, and that death occurred at 9 P.M., from the causes and on the date stated above			22a. SIGNATURE Richard T. Binford			22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>									
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE THEREOF 2/26/61			23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery			23d. LOCATION (City, town, or county) Keedysville Wash Co. a.d.												
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown a.d.			ADDRESS			25a. REC'D BY REGISTRAR DATE FEB 28 '61			25b. REGISTRAR'S SIGNATURE Doris E. Hause												

— *and the* *old* *days* *are* *over*

— *I* *want* *to* *live* *in* *the* *new* *days*

and *the* *old* *days* *are* *over*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

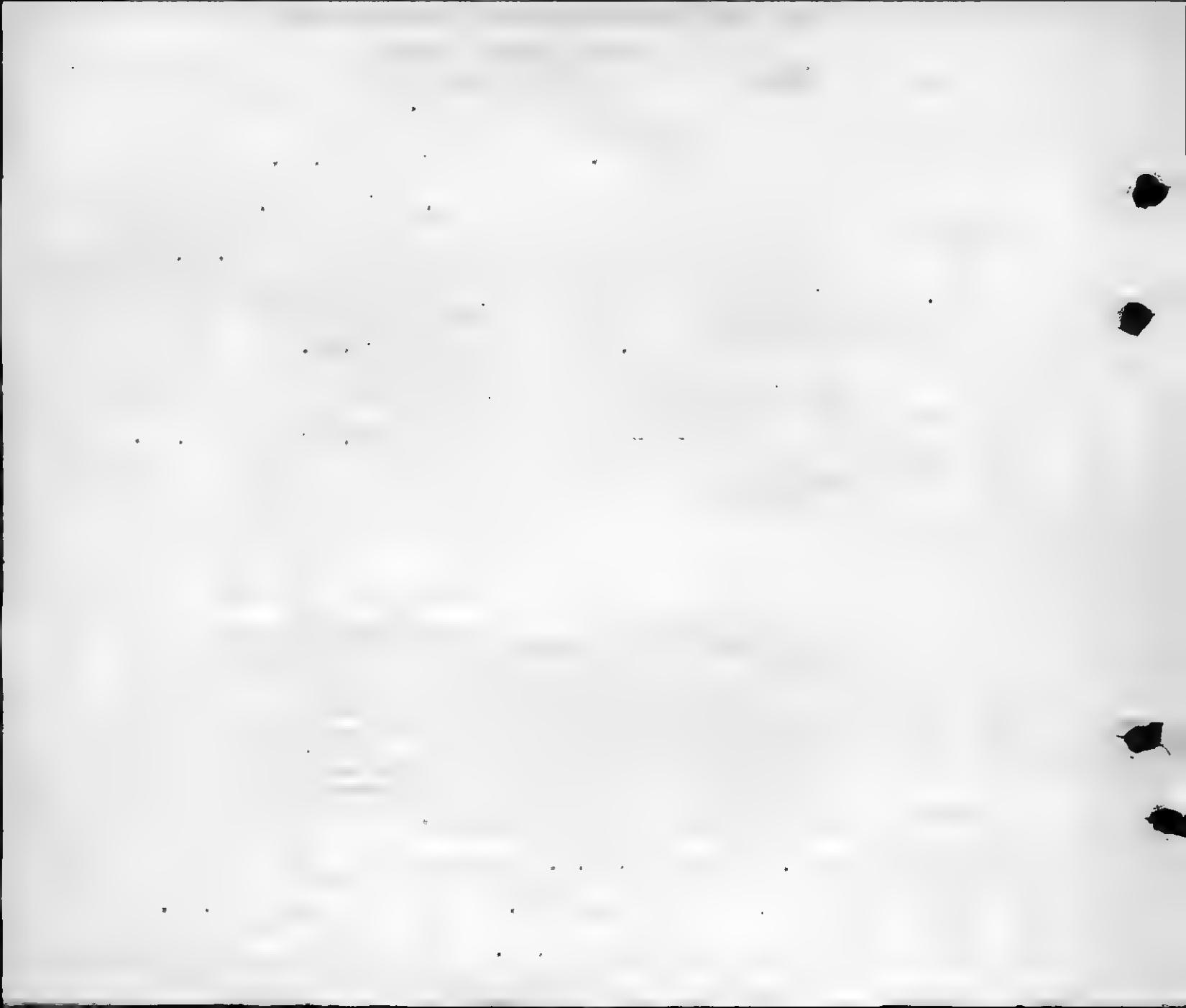
CERTIFICATE OF DEATH

Reg. Dist. No. 024-3

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mercersburg, Pa.	
3. NAME OF DECEASED (Type or print) MARY		d. STREET ADDRESS 26 W. Seminary St.	
4. DATE OF DEATH Feb. 14, 1961		Month	Day
5. SEX Fem.		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/15/1878		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & clerk		10b. KIND OF BUSINESS OR INDUSTRY in Dept. store	
11. BIRTHPLACE (State or foreign country) Mercersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Zimmerman		14. MOTHER'S MAIDEN NAME Joan Scully	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 162-07-6447	
17. INFORMANT Harry Overcash, Mercersburg, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral lobar pneumonia</i> INTERVAL BETWEEN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>generalized arterosclerosis + arteriosclerotic heart disease</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 7, 1961</i> to <i>Feb. 14, 1961</i> , that I last saw the deceased alive on <i>Feb. 10, 1961</i> , and that death occurred at <i>233 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Edward W. Ditto III, M.D.</i> <i>2/17/61</i>			
ACTUAL SIGNATURE EDWARD W. DITTO III, M.D., Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/61	
22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cem.		22d. LOCATION (City, town, or county) Mercersburg, Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. M. Seminger</i>		ADDRESS Mercersburg, Pa.	
24a. REC'D BY REGISTRAR FEB 21 '61		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2468

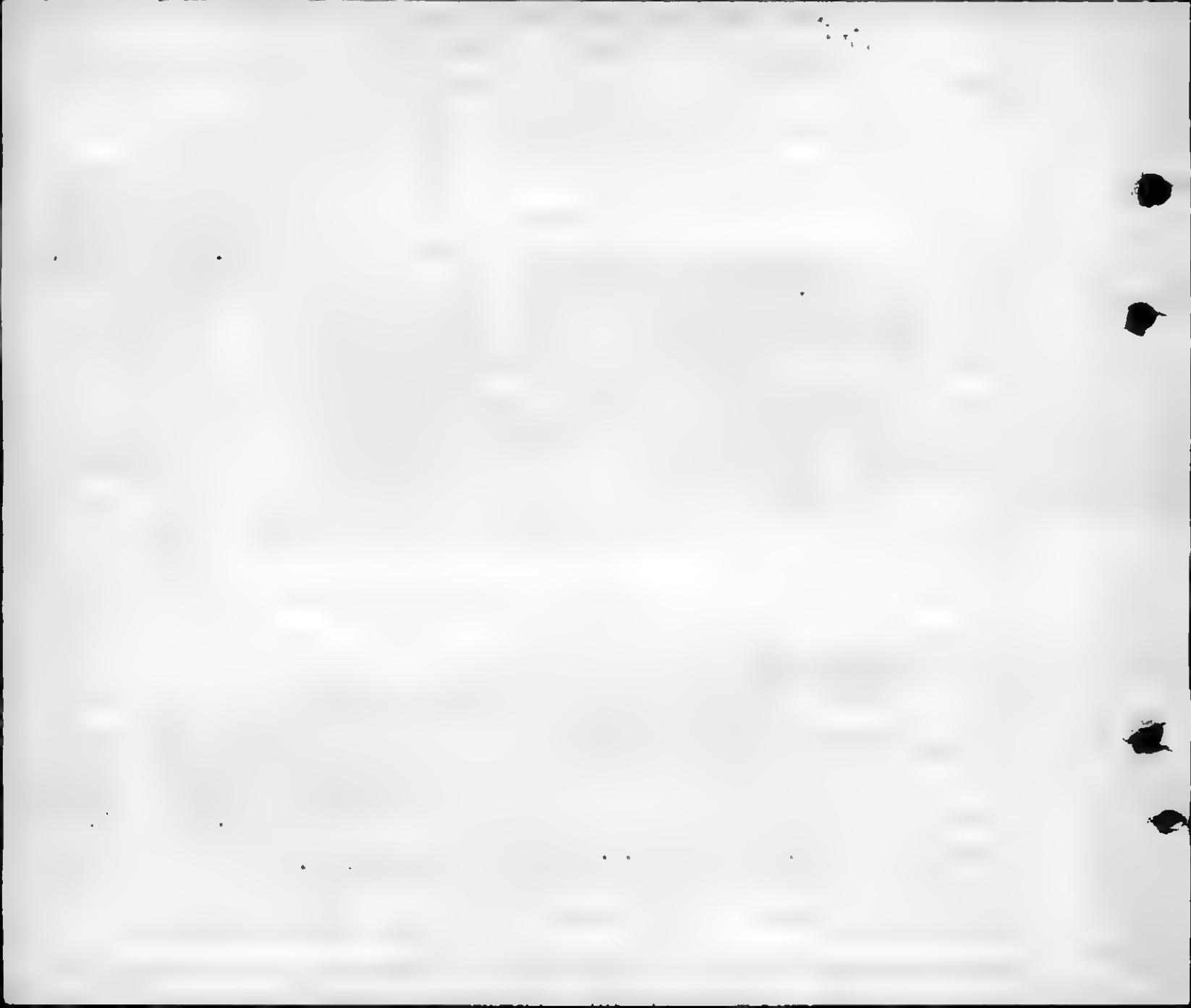
CERTIFICATE OF DEATH

Reg. Dist. No. 12443

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
WASHINGTON MARYLAND		M.D. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN lb 18 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION WASHINGTON Co. HOSPITAL		d. STREET ADDRESS 112 S. PROSPECT ST.	
3. NAME OF DECEASED (Type or print)		First Harry	Middle Varden
4. DATE OF DEATH		5. SEX M	6. COLOR OR RACE Wh.
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 7, 1894	
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Amyg. MACH. SER. Amusement Device		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MERCERSBURG, PA	
13. FATHER'S NAME ADAM S. STEIGER		14. MOTHER'S MAIDEN NAME ORPHA MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N		16. SOCIAL SECURITY NO. 217-16-7605 17. INFORMANT Mrs. H. V. STEIGER, 112 S. Prospect St., Hagerst. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) DUE TO (c) aortic left heart failure hypertensive cardiovascular disease	
		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on		21. I certify that I attended the deceased from alive on 216, 1961, to 216, 1961, that I last saw the deceased and that death occurred at 3:05 PM, from the causes and on the date stated above.	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/9/61	
22c. NAME OF CEMETERY OR CREMATORIAL FAIRVIEW CEM.		22d. LOCATION (City, town, or county) MERCERSBURG, PA	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Linniger		24a. REC'D BY REGISTRAR FEB 10 '61	
ADDRESS MERCERSBURG, PA		24b. REGISTRAR'S SIGNATURE C. Linniger & Son	

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death, or if the physician is not available, the certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2469

12445

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 8 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILKES-MANOR		d. STREET ADDRESS FAIRPLAY MD R1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. Co. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) KAREN SUE STEVENS		First	Middle	Last	4. DATE OF DEATH FEBRUARY - 14 - 1961	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DEC. 11 - 1959	9. AGE (In years last birthday) yrs. 2	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 2	12. Hours 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) WASH. Co. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME DALE STEVENS		14. MOTHER'S MAIDEN NAME FRANCES MARSHALL						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT DALE STEVENS		Address FAIRPLAY MD R1		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dehydration		DUE TO Acute gastro-enteritis		INTERVAL BETWEEN ONSET AND DEATH 24 hours				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 571.9		(b) DUE TO 		(c) 				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Boonsboro, MD		(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 2-13-1961 to 2-14-1961 , that (I) (we) last saw the deceased alive on 2-13-1961 , and that death occurred at 11:45 AM from the causes and on the date stated above.								
22a. SIGNATURE Joseph Secondari		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2/14/61				
22c. PHYSICIAN'S NAME (Type) Joseph Secondari		22d. ADDRESS 21 North Main Street Boonsboro, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 16 1961		23c. NAME OF CEMETERY OR CREMATORIAL MANOR CEMETERY		23d. LOCATION (City, town, or county) NR. WILKES-MANOR MD.		(State)
24. FUNERAL DIRECTOR'S SIGNATURE John W. East		ADDRESS 130 N. Main St. Boonsboro MD.		25a. REC'D BY REGISTRAR FEB 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans		



02446

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 303

2478

If any delay is necessary, please call the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1½ Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 310 Bryan Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ORA	Middle ANN	Last STOTLER
4. DATE OF DEATH	Month Feb	Day 2	Year 1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec 12 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Stotler		14. MOTHER'S MAIDEN NAME Lutie V. Summers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daniel D. Stotler 147 Bellview Ave		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u> DUE TO			
979X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>0 Hypertensive cardiovascular disease</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Suffocated from Plastic bag placed over head.</u>	
20c. TIME OF INJURY Hour a. m. 7 p. m.		Month, Day, Year 2-1-1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hagerstown, Wash. Md.	(County) Wash Co.
20g. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	DATE SIGNED Edward W. Ditto III M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 2/4/61		
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF 3/5/61	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffin Hagerstown Md.	ADDRESS	24a. REC'D BY REGISTRAR FEB 7 '61	24b. REGISTRAR'S SIGNATURE C. T. S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

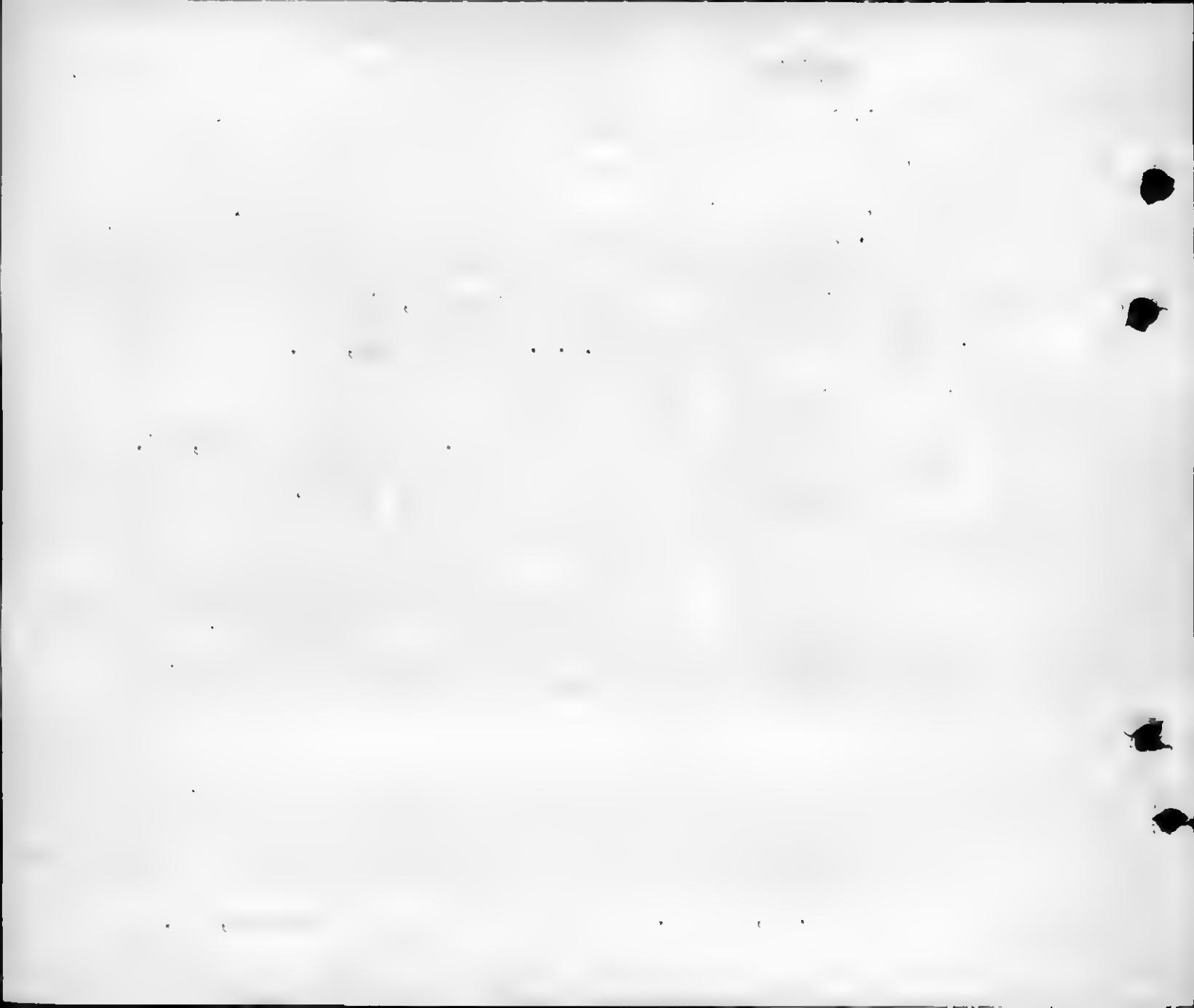
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2471 02447

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital		d. STREET ADDRESS 1220 West Chaplin St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Rodney	Last Swain
4. DATE OF DEATH	Month 2	Day 18	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1872
9. AGE (in years lost birthday) 88 yrs.	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS Days 14	12. IF UNDER 24 HRS Hours 0
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yardman		11. BIRTHPLACE (State or foreign country) Sharpsburg, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Swain		14. MOTHER'S MAIDEN NAME Mary (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Autumn L. Kaiss Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 minutes Unknown	
acute coronary thrombosis Coronary atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip, generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 13 weeks ago fell, sustaining fracture of left hip	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 29 1960</u> to <u>Feb 18 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 18 1961</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> N. S. Chun, M.D. SIGNED N. S. Chun, M.D. SIGNED	
22c. PHYSICIAN'S NAME (Type) Young E. Chun		22d. ADDRESS 1500 Pennsylvania Ave Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 20, '61	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery		23d. LOCATION (City, town, or county) Sharpsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport Md.		25a. REC'D BY REGISTRAR DATE FEB 21 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

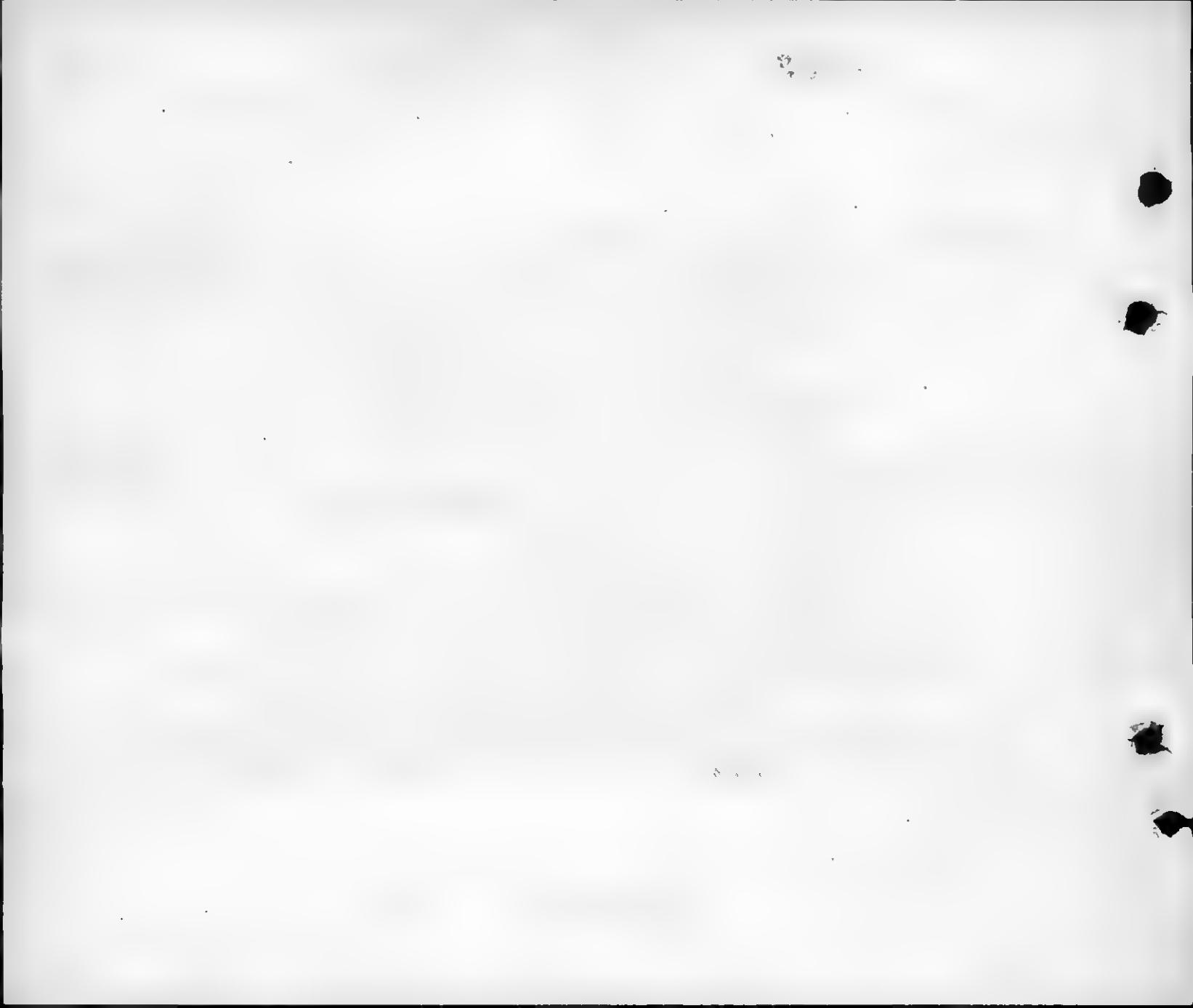


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 File No. 2-20401 et
12418

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 16 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairplay Rt. 1		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH February	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1875 Sept. 30, 1876	9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Downsville, Md		12. CITIZEN OF WHAT COUNTRY? Tilghmanton Md.		
13. FATHER'S NAME Alfred E. Smith		14. MOTHER'S MAIDEN NAME Annie E. Wolford						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT George W. Smith		Address Tilghmanton		
18. CAUSE OF DEATH [Enter only one cause per line for far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH		
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 11/9/61 to 11/9/61, that (I) (we) last saw the deceased alive on 11/8/61, and that death occurred 11/9/61, from the causes and on the date stated above.								
22a. SIGNATURE John F. Young		M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 2-10-61		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Williamsport, Md.						
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-61	23c. NAME OF CEMETERY OR CREMATORIAL Bakerville		23d. LOCATION (City, town, or county) Near Fairplay, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown, Md.	25a. REC'D BY REGISTRAR DATE FEB 15 '61		25b. REGISTRAR'S SIGNATURE Cather & Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2473 CERTIFICATE OF DEATH (1244)

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown Md</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Md Savage Md</i>		d. STREET ADDRESS <i>Box 468 Md Savage</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Western Md Medical Center</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Howard</i>	Middle <i>Andrew</i>	Last <i>B. Twigg</i>	4. DATE OF DEATH	Month <i>2</i>	Day <i>14</i>	Year <i>1961</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 8, 1882</i>	9. AGE (In years last birthday) <i>78</i> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Retired Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Celene Corp of Am. Eckard Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Noah Twigg</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Bloubaugh</i>		Address <i>Mrs. Mary E. McCreedy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> DUE TO <i>9 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>syphilitic Aortic Valvulitis</i> DUE TO <i>unknown</i> (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Cardiac liver cirrhosis, lobular pneumonia.</i>		21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 9, 1960</i> to <i>Feb. 14, 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb. 14, 1961</i> , and that death occurred at <i>3:30 A.M.</i> from the causes and on the date stated above	
22a. SIGNATURE <i>Young E. Chun</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>Young E. Chun M.D.</i>		22d. ADDRESS <i>1500 Penna. Ave. Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2/17/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Porter Cem.</i>		23d. LOCATION (City, town, or county) <i>Eckard Maryland</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James Stein Inc. Cumb. Md.</i>	ADDRESS			25a. REC'D BY REGISTRAR <i>Arthur G. Kraus</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur G. Kraus</i>		
DATE <i>FEB 20 '61</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death, or by the hospital or attending physician.

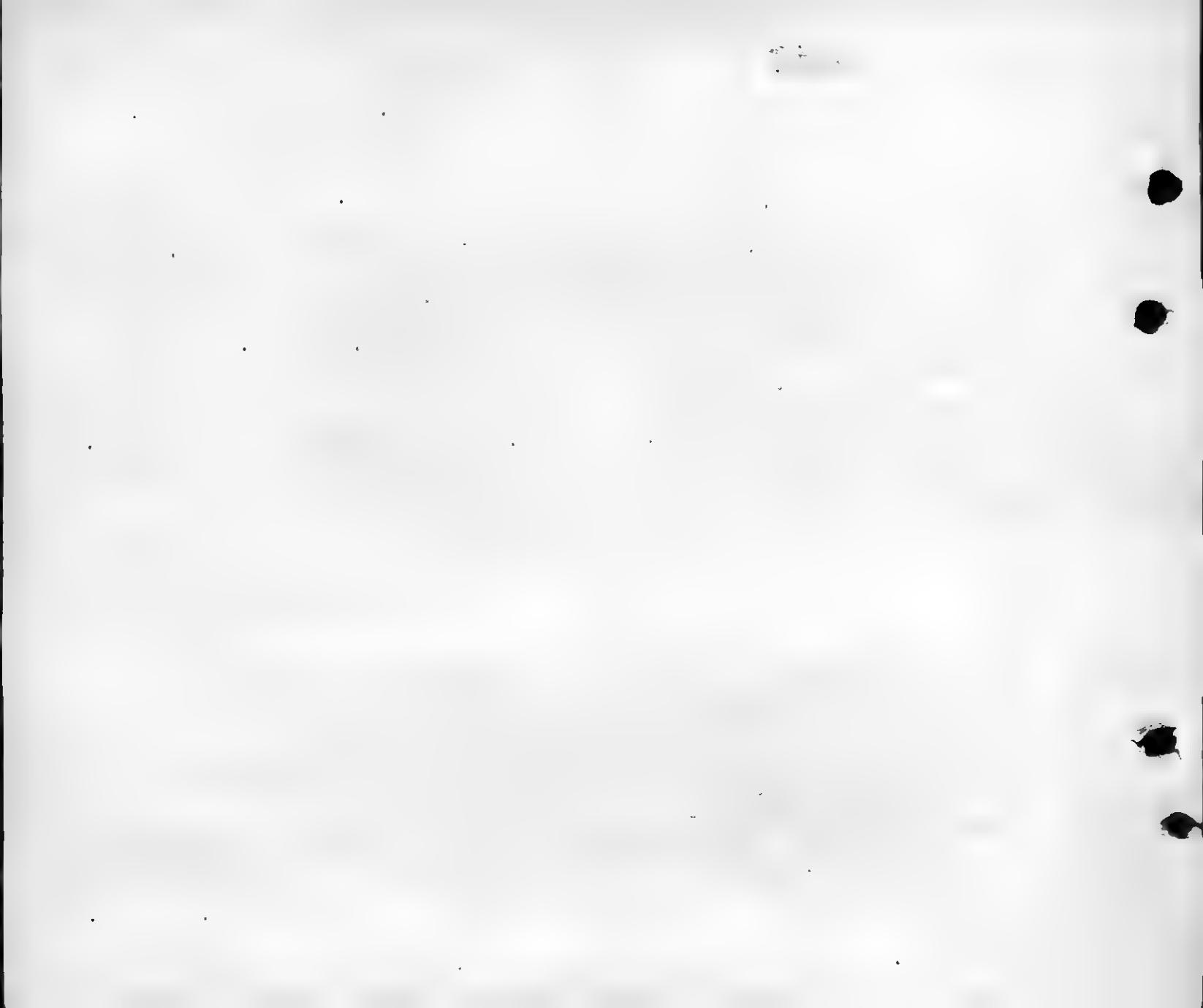
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

112450

1. PLACE OF DEATH a. COUNTY		2474 Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna.		b. COUNTY Bedford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 27 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Everett		d. STREET ADDRESS 10 Main St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Russell	Middle Lewis	Last Wigfield	4. DATE OF DEATH	Month Feb.	Day 22	Year 1961
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1881	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bedford Co., Penna.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME James C. Wigfield		14. MOTHER'S MAIDEN NAME Elizabeth Howsare						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO - - -		17. INFORMANT Mrs. Walter Wells, Hagerstown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days				
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Labar Penumonia		12 days				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1-28 1961 to 2-21 1961, that (I) (we) last saw the deceased alive on 2-21 1961, and that death occurred at a M, from the causes and on the date stated above						22b. DATE SIGNED		
22c. SIGNATURE <i>Searl Young</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						
22d. ADDRESS SEARL YOUNG M.D. 448 M. POTOMAC								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-61		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Bedford Co., Penna.		
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich		ADDRESS Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. It may be retained by the hospital or attending physician, and completely filled in by the funeral director.

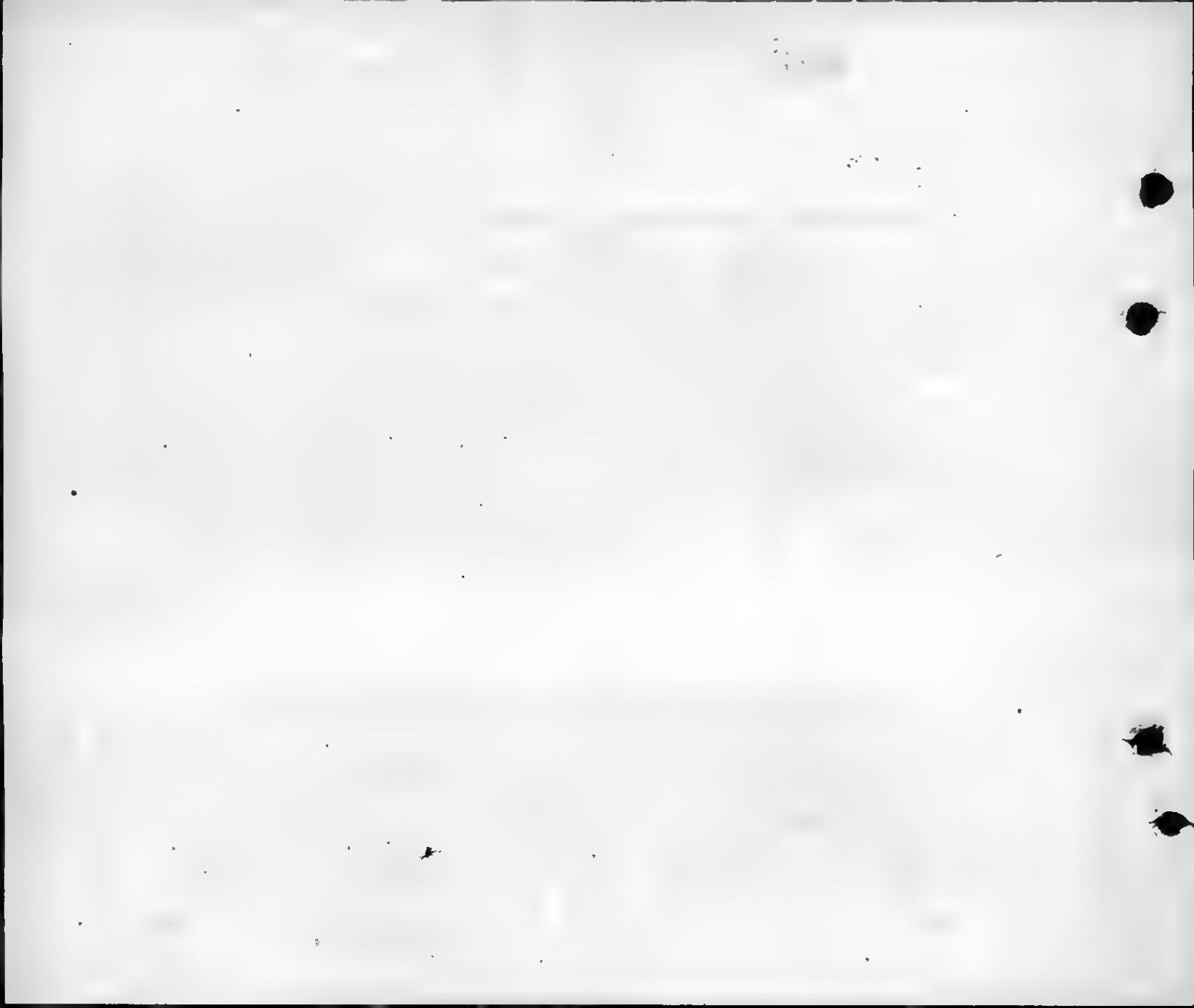
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 303

02451

2475		303	
1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 431 Antietam Drive	
3. NAME OF DECEASED (Type or print) CLARENCE WASHINGTON		4. DATE OF DEATH February 10 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH October 19 1878	
8. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) 82 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Fillsons Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Wiley		14. MOTHER'S MAIDEN NAME Elizabeth Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-24-8649A	
17. INFORMANT Harry W. Wiley Hagerstown Md. R # 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last 2. DUE TO 3. DUE TO		Day Road Carcinoma of Bladder Cirrhosis of Heart Disease Cirrhosis Liver	
		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		29. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 26</u> 1961, to <u>Feb 10</u> 1961, that (I) (we) last saw the deceased alive on <u>Feb 9</u> 1961, and that death occurred at <u>81st</u> from the causes and on the date stated above		22b. DATE SIGNED 2/10/61	
22a. SIGNATURE <u>Philip J. Hirshman</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL/CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/61	
23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REG. STAR FEB 14 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. ...	



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

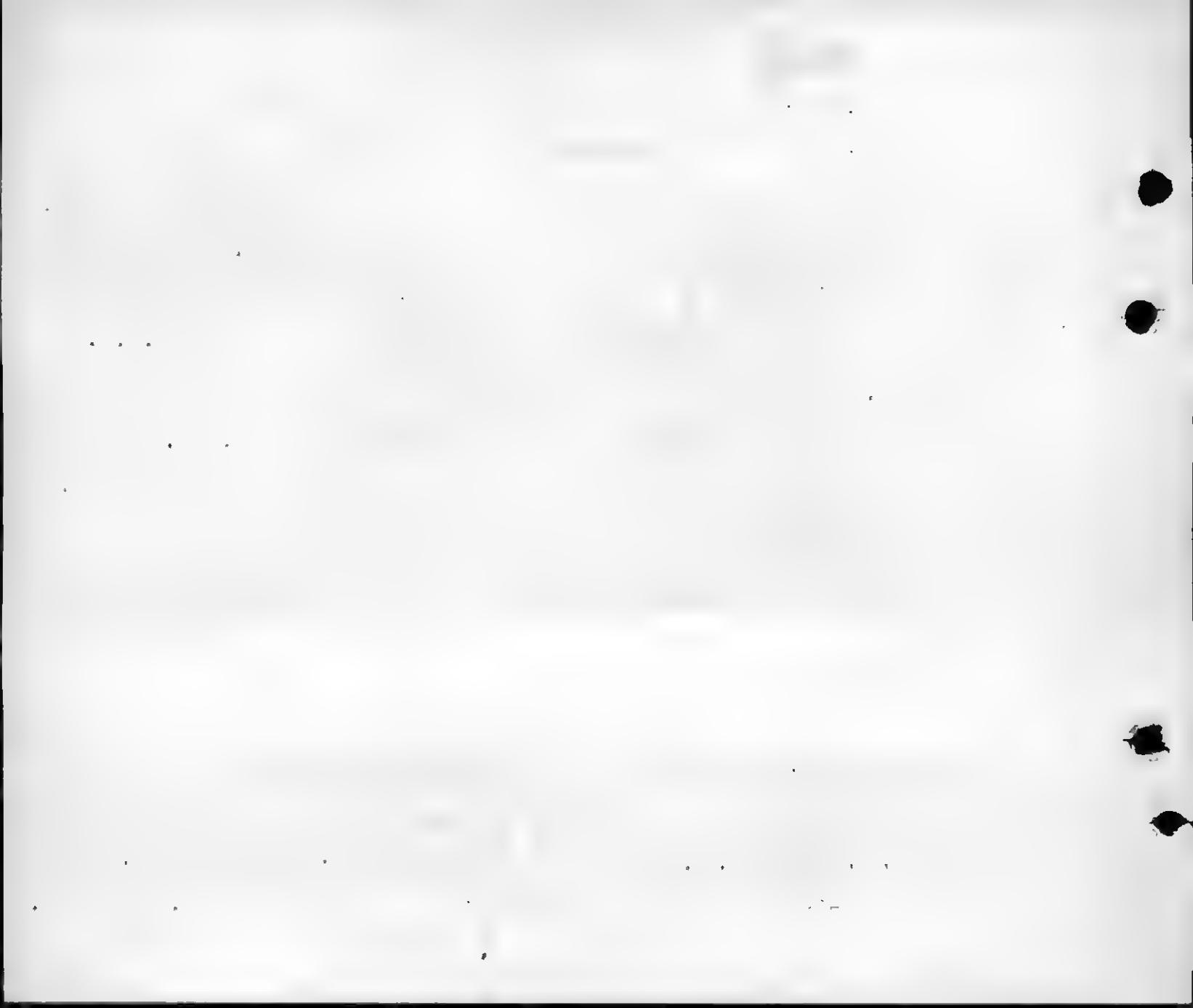
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2476

CERTIFICATE OF DEATH

112452

1. PLACE OF DEATH a. COUNTY		Washington Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington County Hospital		Lifetime		Lantz	
3. NAME OF DECEASED (Type or print)		First GEORGE WASHINGTON WILHIDE		Middle 		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		August 20, 1875	
9. AGE (In years last birthday)		10. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
85 yrs.		Farmer		Own Farm		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service)	
U.S.A.		Josiah E. Wilhide		Julia Freeze		None	
16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)	
None		Albert Wilhide		Mesenteric Thrombosis.		24 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		21. I certify that (I) (this hospital) attended the deceased from 2/27/1961 to 2/28/1961 that (I) (we) last saw the deceased alive on 2/28/1961 and that death occurred at 5:05 AM, from the causes and on the date stated above.		22b. DATE SIGNED	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19		19					
22a. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS	
J. G. Warden, M. D.						832 Potomac Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county) (State)	
Burial		3-3-61		Blue Ridge Cemetery		Thurmont, Md. Fred Co.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Raymond S. Greager		Thurmont, Md.		MAR 6 '61		Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

112453

2477

1. PLACE OF DEATH a. COUNTY WASH.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 201	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) JOHN		First HENRY	Middle WILT
4. SEX M		5. COLOR OR RACE W	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH 3/23/1884		8. AGE (In years last birthday) 76 yrs.	
9. IF UNDER 1 YEAR Months 0 Days 0		10. IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) FRANKLIN Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELIAS WILT		14. MOTHER'S MAIDEN NAME MARTHA ANN FISHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO —	
17. INFORMANT This Mary Gilbert - Wash. D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Artz or - stroke and disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last 4110 (b) Pneumonia. DUE TO (c) Pulmonary edema	
19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 16 1961 to Feb 19 1961 , that (I) (we) last saw the deceased alive on Feb 15 1961 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 2/20/61	
22a. SIGNATURE Edward Hoachlander		22b. ATTENDING PHYS MED. DIRECTOR STAFF PHYS ED <input type="checkbox"/> <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Edward Hoachlander		22d. ADDRESS 115 W Wash St Hagerstown Md	
23a. BURIAL OR CREMATION REMOVED (Specify) B		23b. DATE THEREOF 2/22/61	
23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL		23d. LOCATION (City, town, or county) (State) GREENCASTLE PA.	
24. FUNERAL DIRECTOR'S SIGNATURE A. E. Mynuchs - Greencastle Pa.		25a. ADDRESS —	
25b. REC'D BY REGISTRAR —		25c. DATE FEB 23 '61	
25d. REGISTRAR'S SIGNATURE Charles E. Klemm			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2478

CERTIFICATE OF DEATH

02454

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R. F. D.		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Avalon Manor R# 6		d. STREET ADDRESS Marsh Pike		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JACOB	Middle FORNEY	Last YOUNG Sr	4. DATE OF DEATH	Month February	Day 7	Year 1961
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> October 28 1875	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 85	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Baltimore City Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William S. Young		14. MOTHER'S MAIDEN NAME Emalia Forney		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Temperence Young Hagerstown Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis Pneumonia 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
						10 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-3-161 to 3-7-1961 , that (I) (we) last saw the deceased alive on 2-7-1961 , and that death occurred at 11 AM , from the causes and on the date stated above.							
22a. SIGNATURE Andrew K. Coffman		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-10-61			
22c. PHYSICIAN'S NAME (Type) Andrew K. Coffman		22d. ADDRESS Hagerstown Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/61		23c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		23d. LOCATION (City, town, or county) Hanover (State) York Co Penna	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR DATE 2-14-61		25b. REGISTRAR'S SIGNATURE Arthur S. Brown	

NOTES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02455

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Washington Maryland		Maryland Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. STREET ADDRESS 368 Pangborn Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charlotte	Middle Barbhart
3. NAME OF DECEASED (Type or print)		Lost Zimmerman	4. DATE OF DEATH February 6
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. AGE (In years lost birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housekeeping
11. BIRTHPLACE (State or foreign country) Franklin Co. Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Barbhart		14. MOTHER'S MAIDEN NAME Seville Shook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT None Miss Jane Zimmerman, Hagerstown, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
4430 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Cerebral hemorrhage	
(b) DUE TO Hypertensive Cardiovascular Disease		8 yrs.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>Feb 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>60</u> , and that death occurred at <u>2327</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE Robert P. Conrad M.D.		ADDRESS (Street, city or town, state) 1320 Washington Hagerstown, Md DATE SIGNED 2-7-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1961	
22c. NAME OF CEMETERY OR CREMATORIUM Broadford Cemetery		22d. LOCATION (City, town, or county) Washington Co. Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harold M. Zimmerman, Funeral Home, Pa		24. REC'D BY REGISTRAR DATE FEB 10 '61	
		24. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE GOVERNMENT OF MEXICO - MEXICO, D.F.

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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